COVID-19 ILLNESS/HEALTH ASSESSMENT

I. **Are you or have you recently (within the last 2 weeks) been experiencing any symptoms such as fever, cough, or shortness of breath?**

Yes _____ No _____ Comment: ____

II. **Have you been in close contact with anyone who has been diagnosed with C0VID-19?**

****CLOSE CONTACT** is defined as:

a. Being within approximately 6 feet(2meters) of aC0VID-19 case for a prolonged period of time; close contact can occur while caring for, living with, visiting, or sharing a healthcare waiting area or room with a C0VID-19 case

b. Having direct contact with infectious secretions of a C0VID-19 case (e.g. being coughed on)

Yes _____No _____ Comment: ____

III. **Have you been in close contact* with anyone who may have C0VID-19 but is yet to be confirmed?**

Yes _____ No _____ Comment: ____

IV. **Are you currently in close contact with anyone, such as a family member, who is experiencing symptoms or has been confirmed as positive for COVID-19?**

Yes _____ No _____ Comment: ____

V. **Have you or your immediate family traveled internationally in the last 14 days?**

Yes _____ No ____ Comment: ____

By signing below, I certify all information is true and correct to the best of my knowledge.

____

Printed Name: ___________________________________Date_________________________