COVID-19 SCREENING QUESTIONS

Do you have any of following?

- **Cough**
- **Shortness of breath**
- **Difficulty breathing**
- **Muscle or body aches**
- **Congestion/runny nose**
- **Sore throat**
- **Headache**
- **Loss of taste or smell**
- **Nausea or vomiting/diarrhea**
- **Temperature of 100.4 or higher**

Have you had exposure to COVID-19 in the past 10 Days?