Symptom Self-Certification/Health Screening

Full name of individual wishing to enter the building: _____

Evaluation Questions:

a. Have you received a confirmed diagnosis for coronavirus (COVID-19) by a coronavirus (COVID-19) test or from a diagnosis by a health care professional in the past 14 days?
b. Have you had close contact with or cared for someone diagnosed with COVID-19 within the last 14 days?
c. Have you experienced any cold or flu-like symptoms in the last 14 days (to include: fever or temperature of greater than 99.9 degrees Fahrenheit/38 degrees Celsius, cough, difficulty breathing, sore throat, pressure in the chest, extreme fatigue, earache, persistent headache, diarrhea, and persistent loss of smell or taste)?

How do you respond to these questions? (If you are able to answer "YES" to one or more of the above questions, select YES. If you are able to answer "NO" to all the questions, select NO.)

☐ NO to all questions ☐ YES to any one (or more) of the questions

---

If NO is selected: Based on your answers, you are ALLOWED TO ENTER THE BUILDING.