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?