



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 COVID-19?

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

a. Being within approximately 6 feet(2meters) of a COVID-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 COVID-19 case

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

Yes _____ No _____ Comment: _____

- III. Have you been in close contact* with anyone who may have COVID-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 _____