# Screening Questions:

1. Do you have any of the following symptoms, or pending COVID-19 test because you were having any of the below symptoms?

Fever or chills
Cough
Shortness of breath or difficulty breathing
Fatigue
Muscle or body aches
Headache
New loss of taste or smell
Sore throat
Congestion or runny nose
Nausea or vomiting
Diarrhea

1. Do you have a pending COVID-19 test due to a known or potential exposure?
2. In the last 14 days, have you been exposed to anyone with a lab confirmed COVID-19 test or have you had a COVID-19 positive test result?

 Anyone responding "yes" to any of the three questions should be excluded.