# 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.