Covid 19 Check-in Questionnaire

* Required

1. Please enter your First and Last name *

Enter your answer

2. Please enter your phone number *

Enter your answer

3. Do you have any of the following symptoms? *

- ◯ No
- ◯ Fever of 100.4 degrees or Hotter
- ◯ Chills
- ◯ Shortness of breath or difficulty breathing
- ◯ Cough (excluding chronic cough due to a known medical reason other than COVID-19)
- ◯ Sore throat
- ◯ Diarrhea (excluding diarrhea due to a known medical reason other than COVID-19)
- ◯ Loss of sense of smell and/or taste
- ◯ Fatigue
- ◯ Muscle or body aches
- ◯ Congestion or runny nose
- ◯ Nausea or Vomiting

4. Have you been diagnosed with COVID-19 in the last 14 days? *

- ◯ Yes
- ◯ No

5. Have you had close contact or cared for someone in the past 14 days who has been diagnosed with COVID-19? *

- ◯ Yes
- ◯ No

6. Have you been told by a health care provider or public health official that you must self-quarantine yourself due to potential COVID-19 exposure or because you are suspected of having COVID-19 within the last 14 days? *

- ◯ Yes
- ◯ No

7. Have you traveled domestically or internationally in the last 14 days? *

- ◯ Yes
- ◯ No

Submit