SCREENING QUESTIONS

In the past 14 days have you had COVID-19 symptoms of

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

In the past 14 days have you tested positive for COVID-19?

In the past 14 days have you had close contact with someone who has a confirmed or suspected case of COVID-19?**

***Note that the CDC defines close contact as being less than 6 feet from someone for more than 15 minutes.*

In the past 14 days have you traveled outside the US or to any of the states currently listed on New York State's quarantine list?
https://coronavirus.health.ny.gov/covid-19-travel-advisory