

COVID-19 Screening Questions

Please screen yourself by answering the below questions:

Do you have any of the following symptoms?

1



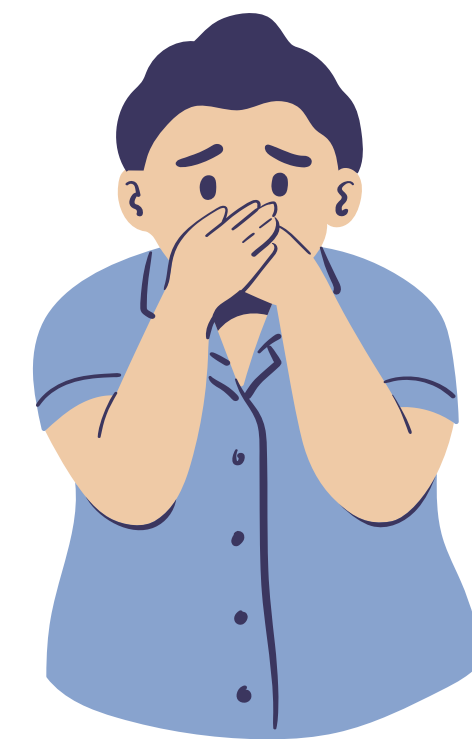
Fever



New or worsening cough, or shortness of breath



Headache



Diarrhea, nausea, vomiting



Sore throat

2

Have you or anyone in your household had a positive COVID-19 test in the last 10 days?



3

Are you a close contact of someone who has tested positive for COVID-19?



If you answered YES to any of the questions, we ask that you leave and return when you are well.