COVID-19 SELF ASSESSMENT

Visitor Name: _________________ Company:_________________________

Date: May 26, 2021

Are you currently experiencing or had any of these symptoms in the last 14 days? (Check any/all that apply)

____ Fever (feeling hot to the touch, a temperature of 100 F/37.8 C or higher)

____ Chills

____ Cough that is new or worsening (continuous, more than usual)

____ Barking Cough (making a whistling noise when breathing)

____ Shortness of Breath (out of breath, unable to breathe deeply)

____ Sore Throat

____ Difficulty Swallowing

____ Runny Nose (not related to seasonal allergies or other known causes or conditions)

____ Congested Nose (not related to seasonal allergies or other known causes or conditions)

____ Lost Sense of Taste or Smell

____ Pink Eye (conjunctivitis)

____ Headache

____ Digestive Issues (nausea/vomiting, diarrhea, stomach pain)

____ Muscle Aches

____ Extreme Tiredness that is unusual (fatigue, lack of energy)

____ Falling down often (lack of balance)

____ Have you tested positive for COVID-19 within the last 14 days?

____ Have you been in contact with someone who tested positive for COVID-19 within the last 14 days?

____ NONE OF THE ABOVE

*** CALL 911 immediately if you are currently experiencing any of the following issues:**

- **Severe difficulty breathing (struggling for each breath, difficulty speaking)**
- **Severe chest pain (constant tightness or crushing sensation)**
- **Feeling confused or unsure of where you are**
- **Losing consciousness**

Visitor Signature____

Received & Reviewed By (Management Personnel) ______________________________