HELP STOP THE SPREAD

HEALTH SCREENING QUESTIONS

1. Have you been in close contact with a confirmed case of COVID-19?

2. Are you experiencing a **cough**, **shortness of breath**, or **sore throat**?

3. Have you had a fever **in the last 48 hours**?

4. Have you had new **loss of taste** or **smell**?

5. Have you had vomiting or diarrhea **in the last 24 hours**?