# Health Screening Questionnaire

## [Member Name]

Date: _____

Name: _____

Department: _____

***Please Complete this Form to be Provided Access to Buildng Each Day.***

| | | YES | NO |
|---|---|---|---|
| 1. | I have one or more symptoms causing me to feel unwell. Symptoms may include, but are not limited to, headache, fatigue/feeling tired, muscle aches, sore throat, cough, sneezing, fever, shortness of breath, recent loss of taste and smell, other respiratory symptoms, and chills. | ☐ | ☐ |
| 2. | I have a household family member who has symptoms as outlined in #1 causing them to feel unwell. | ☐ | ☐ |
| 3. | I answered no to #1 and #2 but I (or a household family member) did have symptoms within the last 72 hours. | ☐ | ☐ |
| 4. | I have traveled (hotel, airplane, etc.) outside of NH in the last 14 days. | ☐ | ☐ |
| 5. | I have had contact with an individual who has tested positive for COVID-19 within the last 14 calendar days. | ☐ | ☐ |
| 6. | I have had contact with an individual who is experiencing virus symptoms such as those indicated in #1, but has not been tested, within the last 14 calendar days. | ☐ | ☐ |
| 7. | I have been involved in other activities that put me at a greater risk to come in contact with COVID-19. | ☐ | ☐ |
| 8. | I have taken my temperature today, it is less than or equal to 100.0 F | ☐ | ☐ |