ATTACHMENT ONE
COVID-19 FORCE HEALTH PROTECTION SCREENING

SCREENING QUESTIONS

1. In the past 14 Days, have you experienced any COVID-19 symptoms? Symptoms include: Fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle aches, body aches, headache, new loss of taste or smell, sore throat, congestion, runny nose, nausea, vomiting, or diarrhea.
2. In the past 14 Days, were you in contact (within 6 feet for more than 15 minutes) with a person who was sick from COVID-19?
3. In the past 14 Days, were you in contact (within 6 feet for more than 15 minutes) with a person who did not have symptoms but tested positive for COVID-19?
4. In the past 14 Days, have you traveled out of state?
5. In the past 14 Days have you tested positive for COVID-19?
6. Do you feel ill today?