Entrance Exam

COVID-19 DAILY SELF-CHECKLIST

NAME	Test Room #
DATE	12/5/2020 ___________

1. Do you have any of these symptoms that are not caused by another medical condition?

SYMPTOM	YES	NO
Fever or chills		
Cough		
Shortness of breath or difficulty breathing		
Muscle or body aches/fatigue		
Headache		
Recent loss of taste or smell		
Sore throat		
Congestion or runny nose		
Gastrointestinal (nausea, vomiting, diarrhea or Loss of appetite)		

2. Do you have a fever (temperature equal to or over 100.4 F) without having taken any fever reducing medication?
   YES ____ NO ____

3. Have you recently been in **close contact** or cared for anyone who has tested positive for COVID-19 or been placed on quarantine for possible contact with COVID-19? Close contact is being 6 feet or closer for more than 15 minutes with a person, or having direct contact with fluids from a person with COVID-19 (ie. being coughed or sneezed on).
   YES ____ NO ____

4. Have you had a positive COVID-19 test in the past ten days?
   YES ____ NO ____

5. Have you been asked to self-monitor, self-isolate or self-quarantine by a medical professional or a public health official within the past 14 days?
   YES ____ NO ____

SIGNATURE: ____

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