QUESTIONNAIRE FOR ALL WHO ENTER OUR BUILDING DURING COVID-19 TIME

1. Have you had a fever, cough, shortness of breath, flu-like symptoms or loss of taste and smell in the last 20 days?

[ ] No

[ ] Yes

If yes, please include details: _____

_____

_____

2. Have you travelled outside of New York State in the last 20 days?

[ ] No

[ ] Yes

If yes, please include details: _____

_____

_____

3. Have you tested positive and been diagnosed with COVID-19?

[ ] No

[ ] Yes

If yes, please include details: _____

_____

_____

4. Have you been in contact with someone who tested positive for COVID-19 or who had symptoms described in number 1 above, within the last 20 days?

[ ] No

[ ] Yes

If yes, please include details: _____

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