COVID-19 Patient Screening Form

1	Are you currently experiencing any of the following symptoms? Cough, fever, shortness of breath, chest pain, loss of taste or smell, flu-like symptoms.	Yes	No
2	Are you in contact with anyone that is COVID-19 positive?	Yes	No
3	Do you have heart disease, lung disease, kidney disease, diabetes, or any auto-immune disorders?	Yes	No

I confirm these answers are accurate.

Name　　　　　　　　　　　　　　Signature　　　　　　　　　　　　　　Date