

Today or in the past 24 hours, have you or any household members had any of the following symptoms:

- Fever
- Temperature of 100 or above
- Felt feverish or had chills
- A cough
- A sore throat
- difficulty breathing
- Gastrointestinal symptoms (diarrhea, vomiting, nausea)
- Severe fatigue
- Headache
- New loss of smell or taste
- New muscle aches
- Any other signs of illness?

In the past 14 days have you had close contact with a person known to be infected with COVID 19?

In the past 14 days have you travelled outside the state?
(Excluding New England, NY, and NJ)