

Waterloo Community Center COVID Screening Questionnaire

Name _____

Address _____

Phone # _____ Date/Time _____

Please answer Yes or No to each question:

If you answer Yes to any question, please leave immediately and return only when you can answer No to each question.

1. Do you have a fever (above 100F)? **Yes** / No
2. Have you had any of the following COVID-19 symptoms within the past 14 days? **Yes** / No
 - Cough
 - Shortness of breath or difficulty breathing
 - Fever
 - Muscle or body aches
 - Headache
 - Chills
 - Sore throat
 - New loss of taste or smell
 - Congestion or runny nose
 - Nausea or vomiting
 - Diarrhea
3. Have you had a positive COVID-19 test within the past 14 days? **Yes** / No
4. Have you had close or proximate contact within the past 14 days with anyone who has tested positive for COVID-19 or who has or had reported symptoms of COVID-19? **Yes** / No
5. Have you re-entered/entered New York State from one of the restricted states in the past 14 days? **Yes** / No

*Please check to confirm you have a mask in your possession available for immediate use: _____

Signature _____

