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 10 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 10 days? Yes / No
4. Have you had close or proximate contact within the past 10 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 10 days? Yes / No

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

Signature_____