COVID-19 HEALTH QUESTIONS CHECK-OFF SHEET

	Do you have any of the following symptoms now or in the past 14 days?										Traveled in the past 14 days.						Quarantined past 14 days								
Name	Fever	Cough	Sore Throat	Shortness of Breath	Loss of taste or smell	Aches/Tiredness	Headaches	Chills	Severe vomiting		Travel Outside U.S.A.		Travel In U.S.A.		Cruise Ship		You or anyone you've been in contact with asked to quarantine?						TEMP.	Date	Initials