# ADMIT ONE

Name: _____ Date: _____

**HOW DO YOU FEEL TODAY?**

1. **Do you have any of the following symptoms that cannot be explained by a chronic condition? YES / NO**

| | | | |
|---|---|---|---|
| Cough | Fever | Chills | Body aches |
| Sore throat | Headache | Fatigue | Diarrhea |
| Runny or stuffy nose | Nausea or vomiting | Loss of taste or smell | Shortness of breath |

2. **Have you been in close contact with someone having COVID-19 or traveled to a high risk area? YES / NO**

**If you answered YES to any of these questions, please stay home.**


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