RARA COVID-19 Mandatory Health Screening

Name: _____ **Date:** _____ **Location:** _____

1. In the past 24 hours, have you experienced:

	Yes	No
Fever or chills (100.4 or above)		
Cough		
Shortness of breath or difficulty breathing		
Fatigue		
Muscle or body aches		
Headache		
New loss of taste or smell		
Sore throat		
Congestion or runny nose		
Nausea or vomiting		
Diarrhea		

2. Contact

a) Have you knowingly been in close contact in the past 14 days with anyone who has tested positive for COVID-19 or who has had symptoms of COVID-19?

[__] **YES** [__] No

b) Have you tested positive for COVID-19 in the past 14 days?

[__] **YES** [__] No

c) Have you experienced any symptoms of COVID-19 in the past 14 days?

[__] **YES** [__] No

d) Have travelled to a state designation by NYS as having widespread community transmission of COVID-19, or travelled internationally in the past 14 days?

[__] **YES** [__] No

Any **YES** in the red area disqualifies for in-person participation. **Any two YES** answer in the other areas disqualifies for in-person participation.