## SYMPTOMS

Are you experiencing any of these COVID-19 symptoms?  |  YES  |  NO  
---|---|---
Cough  |  |  
Fever  |  |  
Chills  |  |  
Sore throat  |  |  
Feeling achy  |  |  
Shortness of breath / difficulty breathing  |  |  
Nausea or vomiting  |  |  
New or unusual headache in the last 24 hours  |  |  
Diarrhea  |  |  
Loss of taste or smell  |  |  
Tingling or numbness  |  |  

## RISK FACTORS

Do any of the following risk factors apply to you?  |  YES  |  NO  
---|---|---
In the last 24 hours have you been in contact with anyone with a known case of the COVID-19 virus?  |  |  

If you checked "YES" to any of the above questions you may have risk factors for COVID-19. Please contact your primary care provider to seek guidance before you or your child attends school.