

# **ATLANTIAN HEALTH SCREENING QUESTIONNAIRE**

The responsible party for this activity MUST ask each attendee these questions upon arrival at the activity site. If the answer to any of these activities is YES ask the person to leave for the health and safety of other attendees.

Questions:

**Have you been within 6 feet of a person with a lab-confirmed case of COVID-19 for at least 5 minutes, or had direct contact with their mucus or saliva, in the past 14 days?**

Yes \_\_\_\_\_ No \_\_\_\_\_

**In the last 48 hours, have you had any of the following NEW symptoms?**

\_\_\_\_\_ Fever of 100 F (37.8 C) or above, or possible fever symptoms like alternating chills and sweating

\_\_\_\_\_ Cough

\_\_\_\_\_ Trouble breathing, shortness of breath or severe wheezing

\_\_\_\_\_ Chills or repeated shaking with chills

\_\_\_\_\_ Muscle aches

\_\_\_\_\_ Sore throat

\_\_\_\_\_ Loss of smell or taste, or a change in taste

\_\_\_\_\_ Nausea, vomiting or diarrhea

\_\_\_\_\_ Headache

**Has a public health official advised you to get tested for COVID-19 in the last 2 weeks?**

Yes \_\_\_\_\_ No \_\_\_\_\_