HEALTH SCREENING ASSESSMENT Covid-19 Questionnaire

As mandated by New York State, this form must be completed by each participant to screen for possible exposure to the COVID-19 Virus. Answers will remain confidential in accordance with State and federal law and will be held for a period of at least 30 days.

Personal information:

Date: ____ ____ First: _____ Last: _____

Phone: _____ Email: _____

1) In the last 14 days, have you tested positive for COVID-19?

____ Yes or ____No

2) In the past 14 days, have you experienced symptoms of COVID-19 that you cannot attribute to another health condition?

_____Yes or ____No

3) In the past 14 days, have you been in close contact (within 6 feet) for more than 10 minutes with anyone who has tested positive for COVID-19 in the last 14 days, or who has or had symptoms of COVID-19 in the last 14 days?

_____ Yes or ____No

4) In the past 14 days, have you spent longer than a 24-hour period of time in a state that is, or was before you left the state, subject to quarantine restrictions on travelers arriving in New York State?

_____ Yes or _____ No

Signature: I hereby affirm that to the best of my knowledge, all answers above are true

_____ _____ _____

Name **Signature** **Date**