RESTORE ILLINOIS WELLNESS SCREENING

Name_____ Date_____

Anyone entering the building must answer the following questions:

Have you felt feverish? YES NO

Do you have a cough? YES NO

Do you have a sore throat? YES NO

Have you been experiencing difficulty breathing or shortness of breath? YES NO

Do you have muscle aches? YES NO

Have you had a new or unusual headache *(e.g. not related to caffeine, diet, or hunger, not related to a history of migraines, clusters, or tension, not typical to individual)*? YES NO

Have you noticed a new loss of taste or smell? YES NO

Have you been experiencing chills or rigors *(a sudden feeling of cold with shivering accompanied by rise in temperature)*? YES NO

Do you have any gastrointestinal concerns *(e.g. abdominal pain, vomiting, or diarrhea)*? YES NO

Is anyone in your household displaying any symptoms of COVID-19? YES NO

To the best of your knowledge, have you or anyone in your household come into close contact with anyone who has tested positive for COVID-19? *Close contacts include household contacts, intimate contacts, or contacts within 6 feet for 15 minutes or longer (10 minutes or longer for ambulatory care services) unless wearing an N95 mask during period of contact.* YES NO