

Name: _____ Date: _____

Within the last 72 hour period have you (or any member of your household) had:

- _____ Temperature above 100°F
- _____ Cough
- _____ Shortness of breath or difficulty breathing
- _____ Fever
- _____ Chills
- _____ Muscle pain
- _____ Sore throat
- _____ New loss of taste or smell

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