Health Screening Questionnaire

First Name _____ Last Name _____

Email address _____ Mobile number _____

What was your temperature reading today? _____

Please answer the following with YES or NO, to the best of your knowledge:

1. Are you currently experiencing any signs or symptoms of any type of sickness? _____

2. Have you experienced any cold or flu-like symptoms in the past 14 days (fever, cough, sore throat, respiratory illness, difficulty breathing)? _____

3. Have you been diagnosed (tested positive) with COVID-19 within the past month? _____

4. Are you under quarantine directed by a healthcare provider due to COVID-19 concerns? _____

5. Have you had contact with someone diagnosed with COVID-19 in the past 14 days? _____

6. Have you had contact with someone who had contact with someone diagnosed with COVID-19 in the past 14 days? _____

7. In the last 14 days, have you, someone living in your household, someone you've been in close or frequent contact with or someone who you are caring for returned from or made a travel connection through a foreign CDC Level 2 or Level 3 country or State Department Level 3 or Level 4 country, for example, China, Korea, Japan, the European Union, Iran? _____

8. Do you have all required project supplies and PPE (mask, work gloves, hand sanitizer, sunscreen)? _____

9. Do you have enough food and water for the day (water totaling at least 3 liters, lunch and snacks)? _____

Signature _____ Date_____