COVID-19 Health Screen

Before coming to practice, answer these questions:

1	**WITHIN THE PAST 10 DAYS, HAVE YOU BEEN DIAGNOSED WITH COVID-19 OR HAD A POSITIVE COVID-19 TEST RESULT?**	**IF YES, PLEASE STAY HOME**
2	**WITHIN THE PAST 10 DAYS, HAVE YOU HAD CLOSE CONTACT* WITH SOMEONE WHO HAS BEEN IN ISOLATION FOR COVID-19 OR HAD A POSITIVE COVID-19 TEST RESULT?** **Close contact is less than 6 feet for 15 minutes or more*	**IF YES, PLEASE STAY HOME**
3	**WITHIN THE PAST 3 DAYS, HAVE YOU HAD ONE OR MORE OF THESE SYMPTOMS:** FEVER, CHILLS, COUGH, LOSS OF TASTE OR SMELL, OR SHORTNESS OF BREATH OR DIFFICULTY BREATHING?	**IF YES, PLEASE STAY HOME**
4	**WITHIN THE PAST 3 DAYS, HAVE YOU HAD ONE OR MORE OF THESE SYMPTOMS THAT ARE NEW OR NOT EXPLAINED BY ANOTHER REASON:** FATIGUE, MUSCLE OR BODY ACHES, HEADACHE CONGESTION/RUNNY NOSE, SORE THROAT, NAUSEA, VOMITING OR DIARRHEA?	**IF YES, PLEASE STAY HOME**

If you say "YES" to any of the questions above:

PLEASE STAY HOME AND report to vpimada@aol.com