VISITOR HEALTH SCREENING FORM

1. HAVE YOU HAD ANY OF THE FOLLOWING SYMPTOMS?
   - ☐ Feverish
   - ☐ Chills
   - ☐ Cough
   - ☐ Shortness of breath
   - ☐ Muscle aches
   - ☐ Headache
   - ☐ Loss of taste or smell
   - ☐ Sore throat
   - ☐ Runny nose
   - ☐ Nausea or vomiting
   - ☐ Abdominal pain

   If **YES** to any, **you are not permitted to enter any city building or facility**.
   If **NO**, please proceed to the next question.

2. DO YOU HAVE A FEVER ABOVE 99.9 DEGREES FAHRENHEIT?
   - ☐ Yes
   - ☐ No

   If **YES**, **you are not permitted to enter any city building or facility**.
   If **NO**, please proceed to the next question.

3. HAVE YOU BEEN DIAGNOSED WITH COVID-19 WITHIN THE PAST 2 WEEKS?
   - ☐ Yes
   - ☐ No

   If **YES**, **you are not permitted to enter any city building or facility**.
   If **NO**, you may enter city buildings or facilities.

WHEN TO SEEK MEDICAL ATTENTION

If you develop any of these emergency warning signs for COVID-19, seek medical attention immediately:

- Trouble breathing
- Persistent pain or pressure in the chest
- New confusion or inability to wake up
- Bluish lips or face