THE TRAINING CENTER - COVID-19 HEALTH QUESTIONNAIRE

In the past fourteen (14) days, have you experienced any of the following symptoms:

Fever (100.4°F or higher):	☐ **Yes** ☐ **No**
Chills:	☐ **Yes** ☐ **No**
Repeated shaking (with chills):	☐ **Yes** ☐ **No**
Cough:	☐ **Yes** ☐ **No**
Shortness of Breath or Difficulty Breathing:	☐ **Yes** ☐ **No**
New Loss of Taste or Smell:	☐ **Yes** ☐ **No**
Muscle or Body Aches:	☐ **Yes** ☐ **No**
Fatigue:	☐ **Yes** ☐ **No**
Congestion or Runny Nose:	☐ **Yes** ☐ **No**
Sore Throat:	☐ **Yes** ☐ **No**
Diarrhea:	☐ **Yes** ☐ **No**
Headaches:	☐ **Yes** ☐ **No**
Nausea or Vomiting:	☐ **Yes** ☐ **No**
Have you been in contact with anyone who has exhibited any of the above symptoms within the last fourteen (14) days?	☐ **Yes** ☐ **No**
Have you been in contact with anyone who has been diagnosed with COVID-19 within the last fourteen (14) days?	☐ **Yes** ☐ **No**
Have you traveled to the Commonwealth of Pennsylvania from another state or international location within the last ten (10) days?	☐ **Yes** ☐ **No**
If your answer to the previous question is yes, have you been tested for COVID-19 within the 72 hours prior to your arrival in the Commonwealth of Pennsylvania and received negative results from the specimen collected, or quarantined for 10 days upon your arrival in Pennsylvania?	☐ **Yes** ☐ **No**

NAME:____ DATE: ________________