Institute Health Screening Questionnaire*

1. In the last 10 days, have you had a positive viral test for COVID-19? **YES ❐ NO ❐**
2. Do you currently have any of the following symptoms? **YES ❐ NO ❐**
   - a. Fever
   - b. Chills
   - c. Cough
   - d. Shortness of breath
   - e. Difficulty breathing
   - f. New fatigue
   - g. Muscle or body aches
   - h. Headache
   - i. New loss of taste or smell
   - j. Sore throat
   - k. Congestion/runny nose
   - l. Nausea and/or vomiting
   - m. Diarrhea
3. In the last 10 days, has anyone in your household been diagnosed with COVID-19? **YES ❐ NO ❐**
4. In the last 10 days, have you been told to quarantine yourself by any public health authority? **YES ❐ NO ❐**
5. In the last 10 days, have you been in close contact (within 6 feet for 15 minutes or more in 24 hours) with someone who has tested positive for COVID-19 without wearing appropriate PPE? **YES ❐ NO ❐**

Printed Name: ______________________________

Signature: ______________________________

Date: ________________

*If you answer YES to any of the above questions, you cannot attend the in-person Institute & Expo.
We encourage you to attend the Virtual Institute Feb. 22-24.