COVID Screening Questions

Please answer questions 1–5.

Do you have…	YES	NO
1 **Fever** or **chills** now or in the last 24 hours?	☐	☐
2 A new cough? Or a cough that is getting worse?	☐	☐
3 *Any* of these problems: – Difficulty breathing – Headache – Feeling tired – Congestion, runny nose – Muscle or body aches – Sore throat – Recent loss of sense of taste or smell – Nausea, vomiting, or diarrhea	☐	☐

In the last 7 days, were you…	YES	NO
4 Told to quarantine yourself?	☐	☐
5 In contact with anyone with COVID?	☐	☐

Any "**YES**" answer to questions 1-5 means:

- You should **stay home** and **contact a health provider** or health department *right away*; and
- You **CANNOT** get care at a *California CareForce* (CCF) Clinic right now.

If you answered "No" to questions 1-5, go to the next questions.	YES	NO
6 Are you fully vaccinated?	☐	☐
6b If "**NO**," have you tested **NEGATIVE** for COVID within the last 3 days?	☐	☐
7 Do you understand that some health problems (including the ones listed below) *increase* your risk of getting a serious case of COVID? – Chronic kidney disease – Type 2 diabetes – Obesity – A weakened immune system – Sickle cell disease – COPD – Serious heart conditions, like heart failure, coronary artery disease, cardiomyopathy	☐	☐

? If you do not understand question #7, please contact a healthcare professional **before** going to a *California CareForce* Clinic.

Print Your Name: _____ Sign: _____ Date: _____