COVID-19 Active Screening: Patient / Designated Support Person / Visitor Access to Facilities

1. Do you have **ONE** of the below symptoms?
    - FEVER/SIGNS OF FEVER (e.g., chills, feeling cold, shivers, etc...)
    - LOSS OF TASTE
    - LOSS OF SMELL

    OR

    Do you have any **TWO** the below symptoms?

    - NEW COUGH OR A COUGH THAT IS GETTING WORSE
    - SHORTNESS OF BREATH
    - SORE THROAT
    - RUNNY NOSE/NASAL CONGESTION
    - HEADACHE
    - DIARRHEA
    - LOSS OF APPETITE
    - NEW ONSET OF MYALGIA (muscle pain)
    - NEW ONSET OF FATIGUE
    - PURPLE MARKINGS ON FINGERS OR TOES (for children)
2. Have you had close contact with a confirmed case of COVID-19 in the last 7 days?
3. Have you tested positive for COVID-19 within the past 10 days?