**Covid-19 Screening Questions LHD immunization patients**

1. **Have you or your child(ren) tested positive for COVID-19 in the last 14 days?**
2. **In the past 24 hours, have you or your child(ren) experienced any of the following symptoms?**
	* Fever (above 100.4) or chills
	* Cough
	* Shortness of breath or difficulty breathing
	* Fatigue
	* Muscle or body aches
	* Headache
	* New loss of taste or smell
	* Sore throat
	* Congestion or runny nose
	* Nausea or vomiting
	* Diarrhea
	* Rash
3. **In the last 14 days has anyone in your household been in close contact (6ft or less for more than 15 minutes) with anyone who is experiencing the above symptoms.**
* Yes
* No
1. **In the last 14 days has anyone in your household been in close contact ( 6ft or less for more than 15 minuteswith anyone who has tested positive for Covid-19?**
	* Yes
	* No
	* Not sure