**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