COVID-19 Screening

Please read each question carefully	Please Circle the Answer That Applies To You
Have you experienced any of the following symptoms in the past 48 hours: • fever 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	**YES** **NO**
Within the past 14 days, have you been in close physical contact (6 feet or closer for at least 15 minutes with a person who is known to have laboratory-confirmed COVID-19 or with anyone who has any symptoms consistent with COVID-19?	**YES** **NO**
Have you recently traveled out of the state to any of the states that are currently considered a hot spot by the Ohio Health Department?	**YES** **NO**

Did you answer **NO** to **ALL QUESTIONS**?	Access to our facility is **APPROVED.** Please let our receptionist or your counselor know
Did you answer **YES** to **ANY QUESTION**?	Access to our facility is NOT APPROVED. Please contact us to set up a remote session at 330-493-0083

9/24/2020