

Volunteer Health Screening Questions

Volunteers must complete the following health survey prior to your shift. If you have answered “Yes” to any one of these questions, please cancel your shift and volunteer another time.

Within the last 10 days, including today, have you been diagnosed with COVID-19 or had a positive test confirming you have the virus?

Yes **No**

Have you had close contact* with someone who has been in isolation for COVID-19 or had a test confirming they have the virus?

Yes **No**

Close [contact](#) (you were in a shared airspace with someone who tested positive for COVID-19 for a total of 15 minutes or more over a 24-hour period, in the two days before or 5 days after their onset of symptoms/positive test)

Have you had any of these symptoms within the past 24 hours?

Yes **No**

- Fever, Chills, or Repeated Shaking/Shivering
- Cough
- Sore Throat
- Shortness of Breath, Difficulty Breathing
- Feeling Unusually Weak or Fatigued
- New Loss of Taste or Smell
- Muscle Pain • Headache
- Runny or Congested Nose • Diarrhea
- Nausea or vomiting

I attest that my responses are true and correct to the best of my knowledge.