



Have you performed your COVID-19 self assessment?

Have you, or anyone you have been in contact with, been diagnosed with COVID-19?

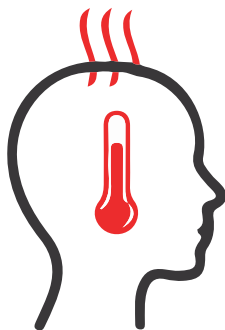
Yes **No**

Do you have or have you had, a fever in the last 24 hours at or above 100° F?

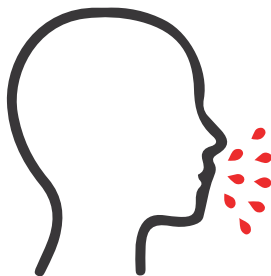
Yes **No**

Do you feel sick?

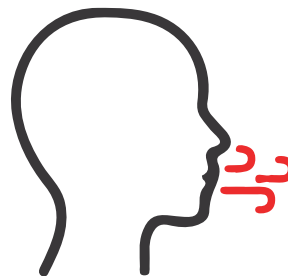
Yes **No**



FEVER



COUGH



SHORTNESS OF BREATH

If you answered YES to any of these questions, PLEASE DO NOT ENTER



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