SCREENING QUESTIONNAIRE

**Volunteers who provide an answer to the following questions other than the required answer may NOT return to volunteer until they are able to answer the questionnaire with all required answers.*

1. Have you had any symptoms of COVID-19 in the past 14 days? Symptoms include any flu-like symptoms, fever, cough, shortness of breath or difficulty breathing, chills and/or repeated shaking with chills, muscle pain, headache, sore throat, loss of sense of smell or taste.
    1. REQUIRED ANSWER: *NO* OR *YES and the volunteer has otherwise received clearance from a qualified medical professional.*
2. Have you been in contact with anyone in the past 14 days who, in that time period, has exhibited or reported experiencing symptoms of COVID-19?
    1. REQUIRED ANSWER: *NO.*
3. Have you received a positive test result for COVID-19 and NOT subsequently received a negative test result?
    1. REQUIRED ANSWER: *NO* OR *YES and the volunteer has otherwise received clearance from a qualified medical professional.*
4. Have you been in contact with anyone in the past 14 days who, in that time period, received a positive test result for COVID-19?
    1. REQUIRED ANSWER: *NO.*