

**City of Carson  
Health Screening Questionnaire**

Name: \_\_\_\_\_ Person or Department You are Visiting : \_\_\_\_\_

Are you currently experiencing or experienced any of the following symptoms within the last 24 hours?

1. Dry cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Sore throat	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Fever above 100.4	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Chills	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Fatigue	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Difficulty breathing/Shortness of breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Muscle Aches	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Loss of smell or taste	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. Gastrointestinal symptoms (nausea/vomiting, diarrhea, loss of appetite)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Indicate which of the above symptoms 1-10 you experienced in the last 14 days including dates of symptoms:

1. Tested for COVID in the past 14 days? If so what was the date of the test and the result.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Been contact traced for potential exposure to COVID? This may be from an individual, an employer, retail business or any other entity. If yes, what was the date?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Been in contact with a confirmed positive COVID-19 individual including being coughed or sneezed on?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Had contact within 6 feet for a period of greater than 15 minutes with a confirmed positive COVID-19 individual within the previous 14 days?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Lived with or provided personal care for a person with a confirmed positive COVID-19 individual within the previous 14 days?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Been ordered to quarantine by healthcare professional or public health authority within the previous 14 days?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Experienced indirect or potential exposure risks but are not experiencing symptoms and none of the other risk factors above apply?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

For any "Yes" answers to questions 1-7, provide details including dates and other relevant information:

By signing below, I certify that all of the above statements are true and no omission or false answer was made in answering the above questions.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date