

Screening Questionnaire

1. Have you had any of the following symptoms in the past 14 days without confirmation as something other than COVID-19 (such as a positive flu test, chronic medical condition, etc.)?

Fever greater than 100.4 deg F?

Cough?

Shortness of Breath or Difficulty breathing?

Sore throat?

Loss of taste or smell?

Headache?

Fatigue?

2. In the last 14 days, have you lived with, visited, cared for, or been in a room for a prolonged period of time with someone who is under investigation or has been confirmed for COVID-19/coronavirus infection?

@ _____ the research be rescheduled for a later date and participants be directed to Florida Department of Health (