COVID-19 SCREENING QUESTIONNAIRE

The safety of our employees and to the public is our overriding priority. As the coronavirus (COVID-19) pandemic continues, we are we are asking everyone to complete and submit this questionnaire prior to entering the courtroom.

PLEASE DO NOT ENTER THE COURTROOM
UNTIL YOUR RESPONSES HAVE BEEN REVIEWED AND YOUR ENTRY HAS BEEN APPROVED.

Name: _____

Phone: _____

Email: _____

1. Are you currently experiencing, or have you experienced in the past 14 days, any of the following symptoms? *(check all that apply)*

   - ☐ Fever ***(your temperature will be verified)***
   - ☐ Cough
   - ☐ Shortness of breath or difficulty breathing
   - ☐ Sore throat
   - ☐ Fatigue
   - ☐ None
   - ☐ New loss of taste or smell
   - ☐ Chills
   - ☐ Headache, muscle or muscle aches
   - ☐ Nausea, vomiting or diarrhea
   - ☐ Congestion or runny nose

2. Within the past 14 days, have you been in close physical contact (6 feet or closer for a cumulative total of 15 minutes) with:
   - anyone who has any of the above symptoms?
     OR
   - anyone who has tested positive for COVID-19?

   ☐ Yes ☐ No

3. Are you isolating or quarantining because you may have been exposed to a person with COVID-19 or are worried that you may be sick with COVID-19?

   ☐ Yes ☐ No

4. Are you currently waiting on the results of a COVID-19 test?

   ☐ Yes ☐ No

5. Within the past 14 days, have you or anyone in your household traveled internationally, domestically to another state or taken a cruise?

   ☐ Yes ☐ No

I hereby certify that the responses provided above are true and accurate to the best of my knowledge.

Signature: _____ Date: _____

COURT USE ONLY:

TEMP: _____ VERIFIED BY: _____

ENTRY APPROVED: ☐ YES ☐ NO