COVID-19 QUESTIONNAIRE

Statement to Volunteers and Visitors*: Please understand that you are answering questions to the best of your ability and that none of us are medical professionals. If you answer "yes" to any of these questions, you will not be allowed to volunteer or visit onsite. Please notify OSOT-America staff as soon as possible.*

Volunteer Name:_____ Date:_____

Please circle your answer, circle "yes" if you understand and agree to these comments.

YES or NO

1. **Have you or someone in your household been ordered to quarantine or self-isolate by a healthcare provider related to concerns of COVID-19? YES or NO**

2. **Have you exhibited symptoms related to COVID-19 in the last 14 days? YES or NO**
    a. Fever
    b. Developed a new cough?
    c. Are you having problems breathing?
    d. Do you feel extra, abnormal pressure on your chest?
    e. Are you abnormally fatigued or exhausted?
    f. Have you had any other symptoms, including vomiting, sinus issues, etc.?

3. **Has anyone in your household exhibited symptoms related to COVID-19 in the last 14 days? YES or NO**
    a. Fever
    b. Developed a new cough?
    c. Are you having problems breathing?
    d. Do you feel extra, abnormal pressure on your chest?
    e. Are you abnormally fatigued or exhausted?
    f. Have you had any other symptoms, including vomiting, sinus issues, etc.?

4. **Have you had direct exposure to anyone who has tested positive for COVID-19? YES or NO**
    a. If Yes, when?_____

5. **To your knowledge, have you had 2nd hand exposure to anyone who has tested positive for COVID-19? YES or NO**
    a. If yes, when?_____

Signature_____

5.18.20