Attachment C

SCREENING SYMPTOMS QUESTIONNAIRE

In the interest of monitoring the safety of all those entering the Sublette County District Courtroom, please complete this Questionnaire.

This Questionnaire is NOT intended to take the place of consultation with your healthcare provider or to diagnose or treat conditions. Regardless of your answers, if you feel that you have symptoms related to COVID-19 contact a health care professional and inform the court.

Please Circle the Answer to each of the following Questions:

1. In the past 14 days, have you had close contact (within six (6) feet for ten (10) minutes) with any person who has a lab confirmed case of COVID-19? Y / N

2. In the last 48 hours, have you had any of the following SYMPTOMS:

    a. Fever, 100F or above, or fever symptoms, alternating chills and sweating? Y / N

    b. Cough? Y / N

    c. Trouble breathing, shortness of breath, or severe wheezing? Y / N

    d. Fatigue? Y / N

    e. Muscle or body aches? Y / N

    f. Sore throat? Y / N

    g. New loss of smell or taste, or change in taste? Y / N

    h. Nausea, vomiting or diarrhea? Y / N

    i. Headache? Y / N

    j. Congestion or runny nose? Y / N

    k. Loss of hearing? Y / N

3. Do you have any reason to believe these symptoms are not COVID-19 related? Y / N

4. Your current temperature is: _____

_____ _____

Print Your Name Date