NH DIVISION OF
Public Health Services
Department of Health and Human Services

COVID-19 Screening Tool

If your answer is "YES" to any of the following questions, please do not enter the building, and contact your supervisor for more information. Thank you!

1. Do you have any of the following symptoms of COVID-19?
    a. Temperature of 100.0 F or greater, or have you felt feverish?
    b. Respiratory symptoms such as cough, sore throat, runny nose, nasal congestion, or shortness of breath?
    c. General body symptoms not due to another chronic medical condition, such as fatigue, muscle aches, joint aches, headache?
    d. Nausea, vomiting, or diarrhea?
    e. Change in your sense of taste or smell?

2. Have you had close contact with anyone with who is suspected or confirmed to have COVID-19 in the last 14 days?
   (Note: healthcare providers caring for COVID-19 patients while wearing all appropriate PPE should answer "no")

3. Have you traveled in the prior 14 days outside of New Hampshire, Vermont, Maine, Massachusetts, Connecticut, or Rhode Island?