Some Place
Like Home, Inc.

NAME: ______________________________________		
Temperature:___________		
HEALTH QUESTIONNAIRE	**YES**	**NO**
DO YOU FEEL SICK TODAY?		
IS YOUR TEMPERATURE 100 OR ABOVE?		
DO YOU HAVE A CHRONIC COUGH?		
ARE YOU EXPERIENCING SHORTNESS OF BREATH?		
HAVE YOU COME IN TO CONTACT WITH ANYONE EXHIBITING THE ABOVE SYMPTOMS?		

I HAVE ANSWERED THE ABOVE QUESTIONS TRUTHFULLY AND AFFIRM THAT TO THE BEST OF MY KNOWLEDGE, I HAVE NOT BEEN EXPOSED TO ANYONE WITH THE ABOVE MENTIONED SYMPTOMS.

SIGNATURE: ________________________________DATE:_____________________ TIME:____________