| Last Name | First Name | Fever | | Cough | | Sore Throat | | Shortness of Breath or Difficulty Breathing | | Close Contact or Cared for Someone with COVID-19 | | Water/Food from Home | | TEMP- IF > 100.4 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Yes | No | Yes | No | Yes | No | Yes | No | Yes | No | Yes | No | |
| | | Yes | No | Yes | No | Yes | No | Yes | No | Yes | No | Yes | No | |
| | | Yes | No | Yes | No | Yes | No | Yes | No | Yes | No | Yes | No | |
| | | Yes | No | Yes | No | Yes | No | Yes | No | Yes | No | Yes | No | |
| | | Yes | No | Yes | No | Yes | No | Yes | No | Yes | No | Yes | No | |
| | | Yes | No | Yes | No | Yes | No | Yes | No | Yes | No | Yes | No | |
| | | Yes | No | Yes | No | Yes | No | Yes | No | Yes | No | Yes | No | |
| | | Yes | No | Yes | No | Yes | No | Yes | No | Yes | No | Yes | No | |
| | | Yes | No | Yes | No | Yes | No | Yes | No | Yes | No | Yes | No | |
| | | Yes | No | Yes | No | Yes | No | Yes | No | Yes | No | Yes | No | |
| | | Yes | No | Yes | No | Yes | No | Yes | No | Yes | No | Yes | No | |
| | | Yes | No | Yes | No | Yes | No | Yes | No | Yes | No | Yes | No | |
| | | Yes | No | Yes | No | Yes | No | Yes | No | Yes | No | Yes | No | |