



WASHTENAW COUNTY TRIAL COURT SCREENING FORM

In the past 48 hours, have you experienced the following symptoms not explained by a known medical or physical condition:

| | | |
|---|------------------------------|-----------------------------|
| Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cough | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Shortness of breath or difficulty breathing | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Loss of taste or smell | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If you answer "yes" to ANY of the symptoms listed above, or if your temperature is 100.4°F or higher, please do not go into the building. Seek COVID-19 testing and isolate at home until test results are available.

In the past 48 hours, have you experienced the following symptoms not explained by a known medical or physical condition:

| | | |
|--------------------------|------------------------------|-----------------------------|
| Abdominal pain | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chills | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Congestion or runny nose | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diarrhea | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Fatigue | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Headache | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Muscle aches | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Nausea or vomiting | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sore throat | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If you answer "yes" to TWO or more of the symptoms listed above, please do not go into the building. Seek COVID-19 testing and isolate at home until test results are available.

In the past 14 days, have you:

| | | |
|--|------------------------------|-----------------------------|
| Been in close contact with anyone confirmed to have COVID-19 (close contact means closer than 6 feet for 15 minutes or more in a 24-hour period, with or without wearing masks) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|--|------------------------------|-----------------------------|

If you answer "yes" to the question above, please do not go into the building. You must quarantine at home for a minimum of 10 days (possibly 14 days) after close contact with a person who has COVID-19.

Are you currently:

| | | |
|--|------------------------------|-----------------------------|
| Under evaluation for COVID-19 (for example, have you recently been diagnosed with COVID-19)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|--|------------------------------|-----------------------------|

If you answer "yes" to the question above, please do not go into the building. You must self-isolate at home while waiting for test results. You must also self-isolate at home after being diagnosed with COVID-19.