



We'll reference **your chart** while you use this tool. Please select all of the following symptoms you are currently experiencing or if you've had exposure to a confirmed COVID-19 positive person: Select all that apply Antigen Surveillance Shortness of Breath <u>Only</u> Difficulty Breathing Fever Repeated Shaking Chills with Chills Muscle Pain Headache Sore Throat New Loss of Taste or Smell Congestion Nausea or Vomiting Diarrhea Cough

**Select Antigen** 

**Surveillance Only** 

