

**Yuma County Combined Courts |** 310 Ash Street, Ste. L, Wray, CO 80758

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**COVID-19 SCREENING QUESTIONNAIRE FOR JURORS**

**Juror Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Juror #: \_\_\_\_\_\_\_\_\_\_ Date:\_\_\_/\_\_\_/\_\_\_**

***Answer ‘yes’ or ‘no’ to the following questions about*** ***yourself****:*

1. Are you currently experiencing any of the following symptoms: Fever or Chills, Cough, Shortness of Breath or Difficulty Breathing, Fatigue, Muscle or Body Aches, Headache, New Loss of Taste or Smell, Sore Throat, Congestion or Runny Nose, Nausea or Vomiting, Diarrhea?

**☐YES ☐NO**

1. Within the last two weeks (14 days), have you experienced any of the following symptoms: Fever or Chills, Cough, Shortness of Breath or Difficulty Breathing, Fatigue, Muscle or Body Aches, Headache, New Loss of Taste or Smell, Sore Throat, Congestion or Runny Nose, Nausea or Vomiting, Diarrhea?

**☐YES ☐NO**

1. Within the last two weeks (14 days), have you been contacted by your doctor or local health department and advised that you have tested positive for COVID-19?

**☐YES ☐NO**

1. Within the last two weeks (14 days), have you been exposed to anyone diagnosed with COVID-19 and/or do you regularly provide in-person care for others who have been exposed to or diagnosed with COVID-19 (this includes healthcare providers)?

**☐YES ☐NO**

**Answer ‘yes’ or ‘no’ to the following questions about the health of *those you live with* (spouse/partner, roommate, family member, etc.):**

1. Within the last two weeks (14 days), has someone that you live with tested positive for COVID-19?

**☐YES ☐NO**

1. Within the last two weeks (14 days), has someone you live with experienced any of the following symptoms: Fever or Chills, Cough, Shortness of Breath or Difficulty Breathing, Fatigue, Muscle or Body Aches, Headache, New Loss of Taste or Smell, Sore Throat, Congestion or Runny Nose, Nausea or Vomiting, Diarrhea?

**☐YES ☐NO**

1. Does anyone you live with regularly provide in-person care for others who have been exposed to or diagnosed with COVID-19 (this includes healthcare providers)?

**☐YES ☐NO**