

SPOTLIGHT DAILY SCREENING QUESTIONS

01

Do you OR anyone in your household have any of these symptoms that are not caused by another condition?

Fever above 100.4, Cough, Sore Throat, Shortness of Breath, Loss of Taste or Smell, Chills, Body Aches, Fatigue, Congestion/Runny Nose, Nausea/Vomiting or Diarrhea

02

Have you had a positive COVID-19 test for active virus in the past 10 days?

IF YOU ANSWER YES TO ANY OF THESE QUESTIONS, PLEASE DO NOT ENTER THE STUDIO.

03

Within the past 14 days, have you had close contact with anyone that you know had COVID-19 or COVID-like symptoms?

04

Within the past 14 days, has a public health or medical professional told you to self-monitor, self-isolate, or self-quarantine because of concerns about COVID-19 infection?



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