Exhibit C

Saint Louis COUNTY PUBLIC HEALTH

Date: _____ Time: _____

Name: _____ Agency: _____

Phone Number: _____

Any recent travel outside the Metro St. Louis area? **YES / NO**

Date of Return: _____

Are you experiencing any symptoms?

Cough: **YES / NO**

Fever: **YES / NO**

Shortness of Breath: **YES / NO**

Any direct exposure to a COVID-19 positive patient other than in a medical capacity while wearing all appropriate Personal Protective Equipment?
YES / NO

Temperature: _____

Signature:

_____

If denied entry, please note reason:

_____

___