COVID-19/CORONAVIRUS SCREENING QUESTIONS

Name: ____

Phone: ____

Visiting/Purpose: ____

Have you experienced any of the following symptoms within the last 48 hours:

Fever   Yes ___ No ___

Cough? Yes____ No____

Shortness of breath? Yes ____ No ____

Chills?   Yes____ No___

Repeated shaking with chills? Yes____ No_____

Sore Throat? Yes____ No____

Headache? Yes _____No _____

Muscle or body aches? Yes____ No_____

New Loss of aste or smell? Yes ____ No ____

Congestion and runny nose? Yes____ No_____

Nausea or vomiting? Yes _____ No_____

Diarrhea? Yes____ No____

Or the following within the last 14 days:

Exposure to someone with documented or suspected COVID-19?   Yes ________   No __________

Recent travel to high risk areas?   Yes ________   No __________

Resides in a community where community-Based spread of COVID-19 is occurring?   Yes ________   No __________

Been in close physical contact (6 ft or closer for at least 15 minutes) with a person who is known to have laboratory-confirmed Covid-19 or with anyone who has any symptoms consistent with COVID-19?   Yes______ No______

Are you isolating or quarantining because you may have been exposed to a person with COVID-19 or are worried that you may be sick with COVID-19?   Yes_______ No______

Are you currently waiting on the results of a COVID-19 test?   Yes______ No_____

If you answered yes to any of these questions, please do not enter our facility.
Thank you for helping keep everyone healthy and safe.

Signature: ____

Date: ________________________________   Time: ___________________________