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: __________________________