Date: _____

Screening Tool

Person's Name:_____

Please let us know if you have had any of the following:

	YES	NO
Fever of 100.4°F	☐	☐
Cough, difficulty breathing, sore throat, or loss of taste or smell?	☐	☐
Have you had a test for COVID-19 in the last 14 days?	☐	☐
Have you had contact within the last 14 days with anyone who diagnosed with COVID-19?	☐	☐

Please do not write below this line. Official Use Only

_____

Temperature:_____

Staff signature: _____