COVID-19 Screening Tool

Date: _____ Name: _____

Reason for entering facility: _____

Please let us know if you have had any of the following:	Yes	No
Fever (temperature of 100.4 or more		
Chills		
Cough		
Shortness of breath, difficulty breathing		
Fatigue		
Body/muscle ache or pain		
Headache		
New loss of taste or smell		
Sore throat		
Runny or stuffy nose		
Nausea, vomiting		
Diarrhea		

If the answer to any question is "Yes", the staff or visitor should be excluded from the facility until:

- They are completely fever free for 24 hours, without medication
  AND
- 10 days have passed since their first symptoms started
  AND
- Symptoms have resolved.

In the last 14 days:	Yes	No
Has anyone in your household been diagnosed with COVID-19?		
Have you been told to quarantine by any public health authority? If so, when does/did your 14-day quarantine end?		
Have you been in close contact (less than 6 feet for greater than 15 minutes) with someone who has tested positive for COVID-19?		
Have you traveled anywhere outside of the 50 United States or on a cruise?		
Have you traveled anywhere in the United States by commercial airlines?		

If the answer to any question is "Yes", the staff or visitor should be excluded from the facility and should self-quarantine until 14 days have passed since the time of potential exposure/travel.

Temperature: _____

Cleared to enter facility? Yes: _____ No: _____

Staff Signature: _____