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 100F or more)		
Cough		
Shortness of breath or difficulty breathing		
Body aches		
Chills		
Runny nose or stuffy nose		
Sore throat		
Diarrhea		

If the answer to **any** question is **"yes"**, the person should be excluded from the facility until:

- They are completely free of symptoms for 72 hours, AND
- 7 days have passed since their first symptoms started

In the last 14 days:

	Yes	No
Has anyone in your household been diagnosed with COVID-19?		
Have you been told to quarantine yourself 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 a prolonged period) 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 person should be excluded from the facility and should self-quarantine until **14 days** have passed since the time of potential exposure/travel.

Do not write below this line. Official Use Only.

Temperature: ___________ Staff signature: ______________________________

Cleared to enter facility? ☐ yes ☐ no