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 or greater in the last 2 days?	☐	☐
Do you have a cough, difficulty breathing, sore throat or loss of taste or smell	☐	☐
Have you had contact with anyone who has Novel coronavirus (COVID-19) within the last 14 days?	☐	☐

Please do not write below this line. Official Use Only

_____

Staff signature: _____

Date: _____

Staff Screening Tool

Staff Name:_____

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

	YES	NO
Fever of 100.4°F or greater in the last 2 days?	☐	☐
Do you have a cough, difficulty breathing, sore throat or loss of taste or smell	☐	☐
Have you had contact with anyone who has Novel coronavirus (COVID-19) within the last 14 days?	☐	☐

Please do not write below this line. Official Use Only

_____

Temperature:_____

Staff signature: _____