Date: ________________

Screening Tool

Person’s Name: ________________________________________

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

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

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: ________________________________
Staff Screening Tool

Staff Name:______________________________________________

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

Fever of 100.4°F or greater in the last 2 days? YES NO

      □□

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:______________________________________________