COVID-19 Screening

Name_________________________________

Date_________________________

Temperature __________________

Are you experiencing:

Cough	Y	N
Sore Throat	Y	N
Difficulty Breathing	Y	N
Vomiting	Y	N
Diarrhea	Y	N
Loss of Taste or Smell	Y	N
Fever in last 72 hours?	Y	N
Contact with someone with COVID-19 in last 14 days?	Y	N
Compromised immune system?	Y	N

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Temperature __________________

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Sore Throat	Y	N
Difficulty Breathing	Y	N
Vomiting	Y	N
Diarrhea	Y	N
Loss of Taste or Smell	Y	N
Fever in last 72 hours?	Y	N
Contact with someone with COVID-19 in last 14 days?	Y	N
Compromised immune system?	Y	N

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