COVID-19 PRESCREENING

Name: ______________________________ Temperature:___________________ Date: _______________

- ★ Have you had close contact with anyone with respiratory illness or a confirmed or probable case of COVID-19?
    - ○ Yes
    - ○ No
- ★ Have you traveled out of the country or to an COVID-19 hot spots or any location for which travel restrictions are recommended by the CDC within the past 14 days?
    - ○ Yes
    - ○ No
- ★ Take the temperature of the individual. Is the temperature 100.4 F or higher?
    - ○ Yes
    - ○ No
- ★ Do you have any of the following new or worsening symptoms or signs?
    - ○ New or worsening cough
    - ○ Shortness of breath
    - ○ Sore throat
    - ○ Runny nose, sneezing or nasal congestion (not allergies)
    - ○ Hoarse voice
    - ○ Difficulty swallowing
    - ○ New smell or taste disorder(s)
    - ○ Nausea/vomiting, diarrhea, abdominal pain
    - ○ Unexplained fatigue/malaise
    - ○ Chills
    - ○ New/Unexplained Headache

Check off any 'yes' answers. If the individual answers YES to any questions, they have not passed. They should go home to self-isolate immediately.