TODAY'S DATE: _____

FACILITIES COVID-19 SCREENING

PLEASE READ EACH QUESTION CAREFULLY	PLEASE CIRCLE THE ANSWER THAT APPLIES TO YOU	
1. Have you experienced any of the following symptoms in the past 48 hours: • fever or chills • cough • shortness of breath or difficulty breathing • fatigue • muscle or body aches • headache • new loss of taste or smell • sore throat • congestion or runny nose • nausea or vomiting • diarrhea	**YES**	**NO**
2. Are you isolating or quarantining because you tested positive for COVID-19 or are worried that you may be sick with COVID-19?	**YES**	**NO**
3. Have you traveled to an area with a high incidence of COVID-19 in the last two weeks?	**YES**	**NO**

4. Have you been in close physical contact in the last 14 days with: • **Anyone who is known to have laboratory-confirmed COVID-19?** OR • **Anyone who has any symptoms consistent with COVID-19?** *Close physical contact is defined as being within 6 feet of an infected/symptomatic person for a cumulative total of 15 minutes or more over a 24-hour period starting from 48 hours before illness onset (or, for asymptomatic individuals, 48 hours prior to test specimen collection).*	**YES**	**NO**
5. Are you feeling ill today? **I**	**YES**	**NO**
6. (Your questions here)	**YES**	**NO**
Temperature at Screening:_____ Hand Hygiene completed on entry?: Y / N		
I certify that my responses are true and correct	☐	

Did you answer NO to ALL QUESTIONS?	Access to facilities **APPROVED**.
Did you answer YES to ANY QUESTION?	Contact Administrator/DON/IP to see if in person Visitation can occur.