COVID-19 Screening Tool

Name________________________________ Date: ______________

Who are you visiting ____

1. Temperature: __________ (documented by designated staff)
2. Have you taken any medication to reduce a fever in the last 24 hours, such as Tylenol, Aspirin, Aleve, Motrin, Dayquil, etc.? Y/N________
3. Cough: Y/N ___________
4. Increased Shortness of Breath: Y/N __________
5. Have you traveled to any level 2/3 designated areas in the last 2 weeks? Y/N___________. If yes, where: ______________________________
6. Have you been in contact with anyone known to have COVID-19? Y/N___________. If yes, how long ago? ________________________
7. Have you been tested for COVID-1: Y/N _______ If yes, when _________ Results: Pos/Neg___________

If any of these questions are answered "yes", you will not be permitted to visit on this day.

Thank you, for your cooperation.

WASH YOUR HANDS

1. Wet hands

2. Get soap

3. Scrub hands together for 20 seconds

4. Rinse

5. Dry