



COVID- 19 ACTIVE SCREENING QUESTIONNAIRE

Your health and well-being are of the utmost importance and we are taking measures to keep the facility/office a safe environment for employees as well as the individuals under our charge and the public. Therefore, anyone coming into the facility /office will be screened and part of our screening process will include taking their temperature and asking the following questions.

*** Required**

DATE * _____

1. NAME* _____
Last First Middle

2. Contact Number * () _____

3. Within the last 14-days, have you experienced a new cough that you cannot attribute to another health condition? *

_____ Yes _____ No

4. Within the last 14-days, have you experienced new shortness of breath that you cannot attribute to another health condition? *

_____ Yes _____ No

5. Within the last 14-days, have you experienced a new sore throat that you cannot attribute to another health condition? *

_____ Yes _____ No

6. Within the last 14-days, have you experienced new muscle aches that you cannot attribute to another health condition or a specific activity such as physical exercise? *

_____ Yes _____ No

7. Within the last 14-days, have you had a temperature at or above 100.4° or the sense of having a fever? *

_____ Yes _____ No

8. Within the last 14 days, have you had close contact, without the use of appropriate PPE, with someone who is currently sick with suspected or confirmed COVID-19?* (Note: Close contact is defined as within 6 feet for more than 15 consecutive minutes) *

_____ Yes _____ No

Signature * _____