COVID SCREENING FORM

Name:

Have you had a positive COVID test within the past 3 months?

Yes **No**

Have you been in close contact with a person known to have COVID-19 OR with anyone with a pending COVID test?

Yes **No**

Have you or any persons in the household received a positive test result or are you awaiting a test result for an active COVID-19 infection?

Yes **No**

Has a health provider recommended you or any persons in the household isolate at home for any reason?

Yes **No**

Are you or any persons in the household currently sick or have the following symptoms?

Fever	Sore throat
Cough	Congestion/runny nose
Chills	Loss of taste or smell
New significant headache- lasting >24 hours with no other cause	Nausea, vomiting, diarrhea

Signature_____