Screening Tool

Person's Name:_____

Please let us know if you have had any of the following:

	YES	NO
Fever of 100.4°F	☐	☐
Cough/Shortness of Breath/Other COVID-19 symptom	☐	☐
Pneumonia - recent	☐	☐
Have returned from overseas travel or from states/metropolitan areas considered hot spots for COVID-19 spread in the last 14 days?	☐	☐
Have you had contact with anyone who has Novel Coronavirus (COVID-19) within the last 14 days?	☐	☐