COVID-19 Screening Tool

Date: _____

Name: _____

1. **TEMPERATURE:**_____°F ☐ Temperature taken on-site ☐ Temperature taken at home

   IF temperature 100.4°F or higher → do not allow into the facility

2. **SYMPTOMS**

Do you have any of the following?

☐ Cough ☐ Shortness of breath

If YES to either → do not allow into the facility

OR

☐ Fever ☐ Sore throat

☐ Chills ☐ Muscle pain

☐ Headache ☐ New loss of taste or small

If YES to 2 or more → do not allow into the facility

3. **VISUAL INSPECTION**

Does the individual have flushed cheeks, rapid breathing or difficulty breathing (without recent physical activity), fatigue, or extreme fussiness (in a child), or cough?

☐ Yes ☐ No Comments:

If YES → do not allow into the facility

4. **EXPOSURE**

Have you been exposed to anyone with a confirmed case of COVID-19 in the past 14 days?

☐ Yes ☐ No Comments:

If YES → do not allow into the facility