Name___________________________________ Date_____________________________

COVID-19 SELF SCREENER

The below is a self-screener that must be completed and submitted upon check in.

Have you experienced ANY of the symptoms in the past 24 hours?	**Yes**	**No**
Fever (100.4) degrees or higher?		
New onset of moderate or severe headache		
Shortness of breath		
New cough		
Sore throat		
Vomiting, diarrhea, or abdominal pain from an unknown cause		
New congestion or runny nose		
New loss of sense of taste or smell		
Nausea		
Fatigue from an unknown cause		
Muscle or body aches		
Had a close contact with a person displaying symptoms of a COVID-19 infection or a person who has tested positive for a COVID-19 infection		
Tested positive for COVID-19 within the past 90 days		

If the answer is “yes” to any of the first 11 questions, do not enter the building and follow up with your healthcare provider