COVID-19 CLINICAL SCREENER

Questions		
1. Have you and/or your responsible adult been in close contact with a person known to have tested positive for COVID-19 in the past **30** days?	YES	NO
2. Have you and/or your responsible adult traveled in the past 14 days? If yes, to where?	YES	NO
3. Have you and/or your responsible adult had any of the following symptoms in the past 14 days?		
▪ Respiratory Symptoms (cough/shortness of breath)	YES	NO
▪ Fever	YES	NO
▪ Chills	YES	NO
▪ Repeated shaking with chills	YES	NO
▪ Muscle pain	YES	NO
▪ Headache	YES	NO
▪ Sore throat	YES	NO
▪ New loss of taste or smell	YES	NO

Signature: _____ DOB _____