COVID-19 Screening Questionnaire

Instructions: Use this screening questionnaire before allowing anyone onto the premises. Deny entry to anyone with a "Yes" response.

Your Name:			
Location:			
City:			
Activity:		Date:	

	Yes	No
1. Is your temperature at or over 100.4 F? Register your temperature here: _____. *If No, then continue.*	____	____
2. Within the last fourteen (14) days, have you tested positive for COVID-19? *If No, then continue.*	____	____
3. Within the last fourteen (14) days, have you had direct contact with a person confirmed or suspected to have COVID-19? *If No, then continue.*	____	____
4. Within the last fourteen (14) days, have you been asked to self-quarantine? *If No, then continue.*	____	____
5. Within the last fourteen (14) days, have you have any cold or flu-like symptoms such as fever, cough, shortness of breath, difficulty breathing, sore throat, body aches, or lack of taste or smell? *If No, then continue.*	____	____
6. Within the last fourteen (14) days, are you aware of being in contact with someone with cold or flu-like symptoms such as fever, cough, shortness of breath, difficulty breathing, sore throat, body aches, or lack of taste or smell? *If No, then continue.*	____	____
7. Within the last fourteen (14) days, have you traveled to a place with rising community transmission of COVID-19? *If No, then continue.*	____	____
8. Within the last fourteen (14) days, have you traveled on an airplane?	____	____

Signature (Parent/Guardian) Date