Confidential Health Screening Form

Information obtained on this form is confidential and should not be shared or distributed to any unauthorized individual. Please follow the instructions to complete the health screening form.

Name:________________________________ Date: ____________

In the past 72 hours have you had any of the following symptoms that are not attributable to another condition?

Yes	No	Condition
		A cough
		Shortness of breath or difficulty breathing
		A sore throat
		A fever of 100.4 F or higher, or a sense of having a fever
		Chills
		New loss of taste or smell
		Muscle of body aches
		Nausea/vomiting/diarrhea
		Congestions/running nose — not related to seasonal allergies
		Unusual fatigue

Does anyone in your household have any of the above symptoms that are not attributable to another condition? Yes, or No

Have you been in close contact with anyone with suspected or confirmed COVID 19? Yes, or No

Have you had any medication to reduce a fever in the past 72 hours? _Yes, or _No .

Temperature ____________

check:(degrees F) Date: ____________Time:

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Individual cleared: Yes, or No Health check

recorded by: ________________________