Coronavirus Disease (COVID-19):
Health Screening Tool _____
Name: _____
Date: _____

In the past 24 hours, have you experienced:
Subjective fever (felt feverish): Yes No
New or worsening cough: Yes No
Shortness of breath:
Sore throat: Yes No
Diarrhea: Yes No
Loss of taste or smell: Yes No

Is your temperature 100.4°F or higher? Yes No

In the past 14 days, have you had close contact with an individual diagnosed with COVID-19? Yes No