COVID-19 SCREENING FORM

FACILITY USER Monitoring Form School/Facility_____ Group Name _____ Group Leader_____ Date_____

Are any of these things true NOW or have they been true in the LAST WEEK?

		Circle Yes/No below																					
Name (list each participant):	**Time**	**Fever**		**Cough**		**Sore Throat**		**Shortness of Breath**		**Recent Loss of Taste or Smell**		**Vomiting or Nausea**		**Shaking with Chills**		**Close contact, or cared for someone with COVID-19**		**Travel to a Covid 19 Hot Spot**		**Diagnosed with Covid 19**		**Temperature (if higher than 100.3 F) Record actual temp**	**True of any other household members?**
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No		
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No		
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No		
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No		
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		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No		
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