## PLEASE NOTE DISCLAIMER AT THE END OF THE DOCUMENT

Work

## Screening Questionnaire — COVID-19 (Coronavirus)

Questions asked at initial screening:					
Name:		Date:			
Please o	circle the appropriate re	sponses.			
1. Do yo a. NO	ou currently have sympto	oms of a res	piratory infectio	nn?	
b. YES	– (If so, please indicate y	our symptoi	ms)		
Fever	Shortness of breath	Cough	Sore throat	Loss of Smell	Loss of Appetite
2. Have a. NO	you traveled outside thi	s area (surro	ounding countie	s) within the past	t 10 days?
b. YES –	(If YES, When? and Whe	ere?)			
3. Have a. NO	you been exposed to so	meone who	has tested posi	tive or diagnosed	with COVID-19?
b. YES –	(If YES, When? and Whe	ere?)			
Provide	er Recommendations (ci	cle one):			

**Do Not Work** 

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