

Health Screening Form

NAME: _____

DATE: _____

Had a fever, sweat, chills, sore throat within the last 14 - 21 days? YES NO

Shortness of breath or other difficulty breathing? YES NO

Do you have a cough? YES NO

Flu like symptoms, such as gastrointestinal upset, headache, fatigue? YES NO

Sore throat or muscle pain within the last 2 days? YES NO

Recent loss of taste or smell? Nausea or vomiting? YES NO

Difficulty waking up or staying awake? YES NO

Is your temperature higher than 100.3? YES NO

Exposed to a person diagnosed with Covid 19 in the past 2 - 14 days? YES NO

Have you tested positive for COVID 19 in the past 14 days? YES NO

Have you traveled outside of the USA, taken a cruise, or visited states noted in the OPWDD travel advisory? YES NO

Comments: