HEALTH SCREENING

YES  NO  Are you exhibiting symptoms of acute respiratory illness (fever, cough, shortness of breath, etc.)?

YES  NO  Have you had close contact with a laboratory confirmed COVID-19 case?

YES  NO  Have you had or been in close contact with someone hospitalized with acute lower respiratory illness of unknown origin?

YES  NO  Do you have a history of travel to or from an affected geographic area with widespread community transmission?

YES  NO  Do you have a history of international travel or cruise within the past 4 weeks?

YES  NO  Are you immunocompromised?

Temperature: ______________

Name _________________________________________ Date ___________

Signature __________________________________________________________________________________