

## COVID-19 Symptom Screening Checklist

This checklist follows guidance from the Centers for Disease Control and Prevention (CDC) for monitoring symptoms consistent with COVID-19, and exposures to the virus that causes it.

Please fill out and return this checklist.

Printed name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Do you have any of the following symptoms that are not caused by another condition?	Yes	No
Fever or chills	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath or difficulty breathing	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Muscle or body aches	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>
New loss of taste or smell	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>
Congestion or runny nose	<input type="checkbox"/>	<input type="checkbox"/>
Nausea or vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>

Have you recently experienced any of the following COVID-19 emergency warning signs?	Yes	No
Trouble breathing	<input type="checkbox"/>	<input type="checkbox"/>
Persistent pain or pressure in the chest	<input type="checkbox"/>	<input type="checkbox"/>
New confusion	<input type="checkbox"/>	<input type="checkbox"/>
Inability to wake or stay awake	<input type="checkbox"/>	<input type="checkbox"/>
Bluish lips or face	<input type="checkbox"/>	<input type="checkbox"/>

COVID-19 Screening Questions	Yes	No
Within the past 14 days, have you been in close physical contact (6 feet or closer for at least 15 minutes) with a person known to have laboratory-confirmed COVID-19 or with anyone who has any symptoms consistent with COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>
Within the past 14 days, has a public health or health care professional advised you to self-monitor, isolate or quarantine because of concerns about COVID-19 infection?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a positive COVID-19 test in the past 10 days?	<input type="checkbox"/>	<input type="checkbox"/>