Name_____**Temp**_____**Date** _____

COVID-19 SCREENING

Accessible version available at *https://www.cdc.gov/screening/*

PLEASE READ EACH QUESTION CAREFULLY	PLEASE CIRCLE THE ANSWER THAT APPLIES TO YOU	
Have you experienced any of the following symptoms in the past 48 hours: • fever or chills • cough • shortness of breath or difficulty breathing • fatigue • muscle or body aches • headache • new loss of taste or smell • sore throat • congestion or runny nose • nausea or vomiting • diarrhea	**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 who is known to have laboratory-confirmed COVID-19 or with anyone who has any symptoms consistent with COVID-19?	**YES**	**NO**
Are you isolating or quarantining because you may have been exposed to a person with COVID-19 or are worried that you may be sick with COVID-19?	**YES**	**NO**
Have you had a positive viral test for COVID-19 in the last 15 days or are you currently waiting on the results of a COVID-19 test?	**YES**	**NO**

Did you answer **NO** to **ALL QUESTIONS**?	Access **APPROVED**. Please give this to the person screening at the facility entrance. Thank you for helping us protect you and others during this time.
Did you answer **YES** to **ANY QUESTION**?	Access **NOT APPROVED**. Thank you for helping us protect you and others during this time.

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REV20200727