VISITOR SCREENING FORM

DATE _____

IN THE LAST 24 HOURS HAVE YOU EXPERIENCED ANY SYMPTOMS OF COVID-19

NAME	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO

SYMPTOMS INCLUDE

COUGH
SHORTNESS OF BREATH
FEVER
CHILLS
HEADACHE
MUSCLE PAIN
SORE THROAT
LOSS OF SMELL OR TASTE