

PANDEMIC SCREENING

NAME OF FACILITY: _____

DATE	PERSON SCREENED	TEMP	PLEASE READ: SCREENING QUESTIONS	YES or NO	STAFF MEMBER SCREENING SIGNATURE
			(1.)100.4°F temp or above (2.) Signs or symptoms of COVID-19 (fever, cough, shortness of breath, difficulty breathing, chills, repeated shaking with chills, muscle pain, headache, sore throat, new loss of taste or smell) (3.) In the previous 14 days had contact w/ someone positive w/ diagnosis of the current pandemic.		
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