NYSIF

ATTACHMENT 8
HEALTH SCREENING QUESTIONNAIRE

BACKGROUND INFORMATION		
Agency:	Date:	Time:
Completed by (name of screener):	Name of individual being screened:	

TEMPERATURE		
Use your no-touch thermometer to take visitor's temperature. Is their temperature greater than or equal to 100.0 degrees Fahrenheit? **NOTE:** Screeners are prohibited from recording visitor health data (e.g. temperatures).	☐ YES	☐ NO

CONTACTS		
Have you had any known close contact with a person confirmed or suspected to have COVID-19 in the past 14 days?	☐ YES	☐ NO

SYMPTOMS		
Are you currently experiencing ANY of the following symptoms?		
Cough (new or worsening)	☐ YES	☐ NO
Shortness of Breath (new or worsening)		
Troubled Breathing (new or worsening)		
Fever		
Chills		
Muscle Pain (new or worsening)		
Headache (new or worsening)		
Sore Throat (new or worsening)		
New Loss of Taste		
New Loss of Smell		

POSITIVE TEST RESULT		
Have you tested positive for COVID-19 through a diagnostic test in the past 14 days?	☐ YES	☐ NO

TRAVEL		
Have you traveled within a state with significant community spread of COVID-19 for longer than 24 hours within the past 14 days?	☐ YES	☐ NO

RESULTS	
Visitor answers "NO" to <u>all</u> questions.	*Visitor answers "YES" to <u>any</u> question.*
☐ Passed	☐ Visitor instructed to return home