



ATTACHMENT 7
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)

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

YES

NO

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 all questions.

Visitor answers "YES" to any question.

Passed

Visitor instructed to return home

STAY HOME.

STOP THE SPREAD.

SAVE LIVES.