COVID-19 – Symptom Assessment Tool

Novel Coronavirus (COVID-19) Screening Tool

Purpose: This tool is intended to assist with screening of visitors for the safety and protection of our patients and staff.

Please circle Yes or No to each question:

Do you have any of the below symptoms:		
➢ Fever >100.4 F or feel feverish	Yes	No
➢ New cough	Yes	No
➢ New shortness of breath/breathing difficulties	Yes	No
➢ Other symptoms such as muscle aches, fatigue, headache, sore throat, or diarrhea.	Yes	No
Have you been around anyone who has been sick with cough and/or fever, and has traveled out of the country within the last 14 days?	Yes	No
Have you been around anyone in the last 14 days that is a confirmed case of COVID 19?	Yes	No

If you answered **NO** to all questions, please sign and date for our records with your phone #

If you answered **YES** to any questions, please speak to the health screener.

Print Name: _____ Date: _____

Phone Number: _____

Visitors Name:_____