COVID19 Screening Questionnaire

First Name: _____

Last Name: _____

1. Have you had a new Fever in the last two weeks? No Yes
2. Have you had a new Cough in the last two week? No Yes
3. Have you had a new Sore Throat in the last two weeks? No Yes
4. Are you short of breath or any difficulties breathing in the last two weeks? No Yes
5. Have you had close contact with anyone with COVID-19 or been to a "hot spot" for COVID-19? No Yes
6. Are you experiencing any other symptoms in relation to COVID-19?
   - ☐ Headache
   - ☐ Chills
   - ☐ Fever
   - ☐ Sore Throat
   - ☐ New Loss of Taste
   - ☐ New Loss of Smell
   - ☐ Muscle Pain / Increased Soreness (Generalized)
   - ☐ None

Temperature reading: _____

Note: If the person's **answer to any of the screening questions is Yes or not None**, or their **temperature is higher than 100.4**, the person **will not be allowed to be in for the practice, meet or meeting**.