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Coronavirus Screening Form

First Name _____ Last Name_____

1) Do you have any of the following symptoms?
   - ☐ Fever or chills
   - ☐ Cough
   - ☐ Sore throat
   - ☐ Shortness of breath/difficulty breathing
   - ☐ Fatigue
   - ☐ Muscle or body aches
   - ☐ New loss of taste or smell
   - ☐ None of the above

2) Have you been in contact with anyone in the last 14 days who is experiencing these symptoms?
   - ☐ Yes
   - ☐ No
   - ☐ Unsure

3) Have you been in contact with anyone in the last 14 days who has tested positive for COVID-19?
   - ☐ Yes
   - ☐ No
   - ☐ Unsure

4) Have you traveled by airplane in the last 14 days?
   - ☐ Yes
   - ☐ No
   - ☐ If yes, please state where and for what reason_____

☐ I acknowledge that the given information submitted is accurate and true to the best of my knowledge. *I also understand that any false statements may be subject to denial of services or care.*

Signature_____ Date_____