Today's Date:__ /__/ __

HEALTH SCREENING QUESTIONNAIRE

I certify that the information provided is correct to the best of my knowledge.

Employee/Visitor Name: (Please Print) _____

Employee/Visitor Name: (Signature) _____

Please complete the below questions:	**Check box that applies:**
Are you fully vaccinated with either the Pfizer, Moderna, or Johnson & Johnson COVID-19 vaccine and are asymptomatic for COVID-19? If yes, no further health screening is required. If no, or if you prefer not to answer this question, proceed with the temperature check and additional health screening questions.	☐ Yes ☐ No
Have you had any of the following symptoms in the last 7 days: • Cough (either new, or different than your usual cough), shortness of breath, or difficulty breathing? • Fever (either subjective, or measured) or chills? • Sore throat, unusual muscle pain, or unusual headache? • New loss of taste or smell? • Nausea, vomiting, diarrhea, or any other flu-like symptoms? ***Current body temperature is_____f (SPO/ screener will complete)***	☐ Yes ☐ No
Within the past 14 days, have you been in close physical contact (6 feet or closer for a cumulative total of 15 minutes) with: • **Anyone who is known to have laboratory-confirmed COVID-19 or** • **Anyone who has any symptoms consistent with COVID-19?**	☐ Yes ☐ No
Are you isolating or quarantining because you may have been exposed to a person with COVID-19 or are worried that you may be sick with COVID-19?	☐ Yes ☐ No

Access Determination:_____Approved _____Denied

SPO/ Name of screener: _____ Date:_____Time: _____