SCREENING FORM FOR: _____

According to the CDC, the term "symptomatic" includes the following symptoms or combinations of symptoms: *Fever, cough, shortness of breath, or at least two of the following symptoms: fever, chills, repeated shaking with chills, muscle pain, headache, sore throat, or new loss of taste or smell.*

DATE: **October 17, 2020**	***IF YOU ANSWER YES TO ANY OF THESE QUESTIONS, OR IF YOU FEEL ILL DURING THE DAY TODAY, PLEASE CONTACT YOUR HEALTHCARE PROVIDER IMMEDIATELY.***		
1. Do you have a fever (over 100.4) today? ◯ YES ◯ NO ◯ DO NOT HAVE A THERMOMETER	2. Have you tested positive for COVID-19 in the past 14 days? ◯ YES ◯ NO	3. Have you knowingly been in close or proximate contact in the past 14 days with anyone who has tested positive for COVID-19 or who has or had symptoms of COVID-19? ◯ YES ◯ NO	4. Have you experienced any symptoms (as defined above) of COVID-19 in the past 14 days? ◯ YES ◯ NO
I hereby attest that the information provided above is true: _____ Signed _____ Date			