COVID-19 Screening

Date: ______________________________

Name: ____________________________

Have you or someone you live with, been in close contact with a confirmed case of COVID-19 within the past two weeks? YES NO

NOTE: Healthcare workers caring for COVID-19 patients while wearing appropriate personal protective equipment should answer "no" to this question

Are you or anyone you live with, currently experiencing a cough, shortness of breath or sore throat not related to allergies? YES NO

Have you or anyone you live with, had a fever in the last 48 hours? YES NO

******If you answered yes to any of these questions, please do not put our employees and other guests at risk and do not show today***

Signature: ______________________________