Novel Coronavirus (COVID-19) Screening Tool

Purpose: This tool is intended to assist with screening of staff for the safety and protection of our patients and staff.

Please review each question:

|  |  |  |
| --- | --- | --- |
| Do you have any of the below symptoms: |  |  |
| * Fever >100.4 F or feel feverish
 | Yes | No |
| * New cough
 | Yes | No |
| * New shortness of breath/breathing difficulties
 | Yes | No |
| * Other symptoms such as muscle aches, fatigue, headache, sore throat, or diarrhea.
 | Yes | No |
| Have you been around anyone who has been sick with cough and/or fever, and has traveled out of the country within the last 14 days? | Yes | No |
| Have you been around anyone in the last 14 days that is a confirmed case of COVID 19? | Yes | No |

If you answered **NO** to all questions, please document NO,

your temperature and sign the Staff Screening Checklist

If you answered **YES** to any questions,

please notify your Supervisor or Employee Health