

COVID-19 Senior Center Participant Health Screening

Participant:

Senior Center Name:

Mode of contact: In-Person Phone

Contact with: Participant
 Family/Caregiver
 Other:

COVID-19 SCREENING	Date	
	Yes	No
1. Are you, or anyone you are living with, experiencing any of the following symptoms? <ul style="list-style-type: none"> • Fever (100+), cough, shortness of breath or difficulty breathing, diarrhea, chills, repeated shaking with chills, muscle pain, headache, sore throat, new loss of taste or smell If yes, when, what, and steps taken to receive medical attention:	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you, someone with whom you have had contact, or anyone you are living with been diagnosed by a positive test and/or a health care practitioner for COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you, someone with whom you have had contact, or anyone you are living with been ill for reasons other than COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you or someone with whom you have had contact been asked to self-quarantine?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you, someone with whom you have had contact, or anyone you are living with traveled out of the state or country in the last 14 days?	<input type="checkbox"/>	<input type="checkbox"/>

Staff Signature:

Title:

Date: