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? • 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:	☐	☐
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?	☐	☐
3. Have you, someone with whom you have had contact, or anyone you are living with been ill for reasons other than COVID-19?	☐	☐
4. Have you or someone with whom you have had contact been asked to self-quarantine?	☐	☐

Staff Signature: Title: Date: