COVID-19 Screening Questionnaire

Full Name

Date

Phone Number

Email Address

Company/Organization

Screening Questions

1. Do you have any of the following symptoms: fever, cough, difficulty breathing, loss of taste or smell?

Yes

No

2. In the past 14 days, have you had close contact with someone who has tested positive for COVID-19?

Yes

No

3. Are you currently awaiting results from a COVID-19 test?

Yes

No

4. In the last 14 days, have you travelled internationally?

Yes

No

Additional Comments