HEALTH SCREENING

BACKGROUND INFORMATION		
Agency:	Date:	Time:
Completed by (name of screener):	Name of individual being screened:	

TEMPERATURE		
Use your no-touch thermometer. Is their temperature greater than or equal to 100.0 degrees Fahrenheit? **NOTE:** Screeners are prohibited from recording visitor health data (e.g. temperatures).	☐ YES	☐ NO

CONTACTS		
Have you had any known close contact with a person confirmed or suspected to have COVID-19 in the past 14 days? Please note close contact does not include individuals who work in a health care setting and are wearing appropriate, required personal protective equipment (PPE).	☐ YES ☐	☐ NO ☐

Travel History		
Have you traveled within a state with significant community spread of COVID-19 for long than 24 hours within the past 14 days? 1. For a list of states currently under New York's travel advisory requiring a 14-day quarantine upon return, please visit https://coronavirus.health.ny.gov/covid-19-travel-advisory.	☐ YES	☐ NO

SYMPTOMS		
Are you currently experiencing ANY of the following symptoms?		
Cough (new or worsening) Shortness of Breath (new or worsening) Troubled Breathing (new or worsening) Fever Chills	☐ YES	☐ NO

Muscle Pain (new or worsening)		
Headache (new or worsening)		
Sore Throat (new or worsening)		
New Loss of Taste		
New Loss of Smell		

Please note a few of the above symptoms may occur with preexisting medical conditions, such as allergies or migraines. You should only answer "YES," if your symptoms are new or worsening.

POSITIVE TEST RESULT

Have you tested positive for COVID-19 through a diagnostic test in the past 14 days?	☐ YES	☐ NO

RESULTS

Visitor answers "NO" to all questions.	*Visitor answers "YES" to any question.*
☐ Passed	☐ Visitor instructed to return home