

COVID-19 ACTIVE SCREENING QUESTIONNAIRE

This will be updated as the CDC and MI State Health Department's information on COVID-19 continues to change.

Your health and well-being are the upmost importance, and we are taking measures to keep our buildings safe. Anyone coming into the building will be asked to complete this questionnaire as part of our screening process.

Within the last 14 days, have you experienced -

1. a new cough that you cannot attribute to another health condition?

YES

NO

2. new shortness of breath that you cannot attribute to another health condition?

YES

NO

3. a new sore throat that you cannot attribute to another health condition?

YES

NO

4. new muscle aches that you cannot attribute to another health condition/specific activity?

YES

NO

5. new loss of taste/smell that you cannot attribute to another health condition?

YES

NO

6. Within the last 14 days, have you had a temp. of 100.4 or greater without using medicine or other signs of a fever?

YES

NO

7. Within the last 14 days, have you had close contact with someone who is currently sick with suspected or confirmed COVID-19?

YES

NO

If you answered YES to any of these questions, please do not enter our buildings.

NAME: _____

Date: _____