BROOKS Rehabilitation

# COVID-19 Screening Tool

**Revised 9/18/20**

**Name_____ Date_____ Time_____**

| | |
|---|---|
| **Do you have a fever greater (>) than 100.4F?** | ☐ **Yes** ☐ **No**<br>Temperature:_____ |
| **Do you live in the same household** or have you had **contact** with anyone who is known to have a positive COVID-19 test result? | ☐ **Yes** ☐ **No** |
| Have you been in **close contact** with anyone who is **confirmed** or is a **suspected case** of COVID-19 without PPE (mask/face shield)…<br>• Within the past 10 days?<br>• Less than 6 feet distance?<br>• Not Including a known work exposure | ☐ **Yes** ☐ **No** |
| Have you been tested for COVID-19 **due to a possible exposure** and are awaiting test results? | ☐ **Yes** ☐ **No** |
| Have you tested positive for COVID-19 and have not been cleared /instructed to return to work ( at least ten days, afebrile 24 hrs without fever reducing meds, resolving symptoms) | ☐ **Yes** ☐ **No** |
| Are you experiencing **shortness of breath?** | ☐ **Yes** ☐ **No** |
| Are you experiencing a **cough**? | ☐ **None**<br>☐ **New or Worsening**<br>☐ **History of Cough**<br>☐ **Related to non-COVID medical condition** |
| Are you experiencing at least two of the following symptoms?<br>**Sore throat** ☐ **Yes** ☐ **No**<br>**Chills** ☐ **Yes** ☐ **No**<br>**Repeated shaking with chills** ☐ **Yes** ☐ **No**<br>**Headache** ☐ **Yes** ☐ **No**<br>**Muscle pain** ☐ **Yes** ☐ **No**<br>**New loss of taste or smell** ☐ **Yes** ☐ **No**<br>**Fever** ☐ **Yes** ☐ **No**<br>**Diarrhea** ☐ **Yes** ☐ **No** | ☐ **Yes** ☐ **No** |

*If there is a "YES" answer to any of the above in the second column, they may not enter facility. Employees should contact their manager.*

Printed Name of Screener _____

Screener Signature _____