VRL Coronavirus Disease (COVID-19) Health Screening

Name: _____ Date: _____

If you answer "yes" to any of the symptoms listed below, or your temperature is 100.4°F or higher, please do not go to into VRL. Self-isolate at home and contact your primary care physician's office for direction.

	YES	NO
IN THE PAST 14 DAYS, HAVE YOU HAD: • Subjective fever (felt feverish) • Shortness of breath or difficulty breathing • Sore throat or cough • Diarrhea nausea or vomiting • Fatigue or muscle or body aches • New loss of taste or smell • Congestion or runny nose • Illness		
IN THE PAST 14 DAYS HAVE YOU COME IN CONTACT WITH ANYONE DIAGNOSED OR SUSPECTED OF HAVING BEEN DIAGNOSED WITH COVID-19?		

Current Temperature	

VRL STAFF/VOLUNTEER WHO REVIEWED FORM: _____

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