COVID-19 Questions Screening

1. Have you been contacted by the CDC, your local department of health and/or placed under self-quarantine for COVID-19 for any reason? (circle one) Y N

If yes Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please circle any of the symptoms listed below that you are experiencing or have experienced in the past 21 days. (If you have/had 2 or more of the listed symptoms please inform staff immediately)
* Fever
* Cough
* Shortness of breath or difficulty breathing
* Chills
* Repeated shaking with chills
* Muscle pain
* Headache
	+ Sore throat
	+ New loss of taste or smell
	+ GI symptoms (diarrhea, nausea, vomiting, pain)
	+ Fever (100.4 or higher)

Temperature \_\_\_\_\_\_\_\_ PPE Present \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DAY 1: Satori Learning Designs staff initials: \_\_\_\_\_

Day 2: Temp\_\_\_\_\_ Initials \_\_\_\_\_ SLD staff initials \_\_\_\_\_

DAY 3: Temp\_\_\_\_\_ Initials \_\_\_\_\_ SLD staff initials \_\_\_\_\_

DAY 4: Temp\_\_\_\_\_ Initials \_\_\_\_\_ SLD staff initials \_\_\_\_\_