COVID-19 Client Prescreen

Name: ____

Date: ____

Have you experienced a fever greater than 100'F in the last 24 hours?

YES / NO

Have you experienced any vomiting or diarrhea in the last 24 hours?

YES / NO

Have you been diagnosed with any contagiouis medical conditions in the last 14 days?

YES / NO

Have you experienced any shortness of breath in the last 14 days?

YES / NO

Have you traveled domestically or internationally to any area with an outbread of COVID-19 in the last 14 days?

YES / NO

Have you or anyone inside your home been exposed to an individual with a confirmed COVID-19 diagnosis?

YES / NO