



## SETRPC COVID-19 SCREENING FORM

Date: \_\_\_\_\_ Employee/Guest Name: \_\_\_\_\_

Time: \_\_\_\_\_ Measured Temperature: \_\_\_\_\_

\_\_\_\_\_ I am currently experiencing the following new or worsening signs or symptoms of possible COVID-19 (Check all below that apply):

\_\_\_\_\_ Cough

\_\_\_\_\_ Loss of taste or smell

\_\_\_\_\_ Shortness of breath or difficulty breathing

\_\_\_\_\_ Diarrhea

\_\_\_\_\_ Chills

\_\_\_\_\_ Feeling feverish or a measured temperature greater than or equal to 100.0 degrees Fahrenheit

\_\_\_\_\_ Repeated shaking with chills

\_\_\_\_\_ Muscle pain

\_\_\_\_\_ Known close contact with a person who is lab confirmed to have COVID-19

\_\_\_\_\_ Headache

\_\_\_\_\_ Sore Throat

\_\_\_\_\_ I am currently NOT experiencing any of the above listed new or worsening signs or symptoms of possible COVID-19.

\_\_\_\_\_  
Employee/Guest Signature

\_\_\_\_\_  
Screener Signature

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