In-Person Meeting Attendee COVID-19 Screening Form

girl scouts
heart of the hudson

Attendee Name: ___________________________ **Date:** ___________

Person Completing Form:___________________________________

Screening Questions

1. Do you have a fever or above-normal temperature (>100F)?	YES ___ NO ___
2. Have you taken fever reducers in the past 72 hours?	YES ___ NO ___
3. Have you been experiencing shortness of breath or having trouble breathing? YES ___ NO ___	
4. In the past 72 hours, have you had a dry cough?	YES ___ NO ___
5. In the past 72 hours, have you had a runny nose?	YES ___ NO ___
6. In the past 72 hours, have you had a sore throat?	YES ___ NO ___
7. Have you recently lost or had a reduction in your sense of smell or taste?	YES ___ NO ___
8. In the past 72 hours, have you had any other flu-like symptoms, such as gastrointestinal upset, headache, muscle pain or fatigue?	YES ___ NO ___
9. In the past 72 hours, have you had chills or repeated shaking with chills?	YES ___ NO ___
10. Have you been tested for COVID-19? If YES, date tested ________ & what is the result? ____ Positive ____Negative ____Awaiting result	YES ___ NO ___
11. In the last 14 days, have you been in contact with someone who has a confirmed case COVID-19, under investigation for COVID-19 or a respiratory illness?	YES ___ NO ___
12. In the last 14 days, have you traveled to any foreign country? If YES, where?__________________	YES ___ NO ___
13. In the last 14 days, have you traveled to a state outside of NY? If YES, where?__________________	YES ___ NO ___