COVID-19 Senior Center Participant Health Screening

Participant:

Senior Center Name:

Mode of contact: ☐ **In-Person** ☐ **Phone**

Contact with: ☐ **Participant**
☐ **Family/Caregiver**
☐ **Other:**

COVID-19 SCREENING	Initial		Pre-Visit	
	Date:		Date:	
	Yes	No	Yes	No
1. Are you, or anyone you are living with, experiencing any of the following symptoms? • Fever (100+), cough, shortness of breath or difficulty breathing, diarrhea, chills, repeated shaking with chills, muscle pain, headache, sore throat, new loss of taste or smell If yes, when, what, and steps taken to receive medical attention:	☐	☐	☐	☐
2. Have you, someone with whom you have had contact, or anyone you are living with been diagnosed by a positive test and/or a health care practitioner for COVID-19?	☐	☐	☐	☐
3. Have you, someone with whom you have had contact, or anyone you are living with been ill for reasons other than COVID-19?	☐	☐	☐	☐
4. Have you or someone with whom you have had contact been asked to self-quarantine?	☐	☐	☐	☐
5. Have you, someone with whom you have had contact, or anyone you are living with traveled out of the state or country in the last 14 days?	☐	☐	☐	☐

Staff Signature: Title: Date: