## COVID-19 SCREENING QUESTIONNAIRE

*To be performed upon entrance to the shelter and daily*

| | | | |
|---|---|---|---|
| *Date* | | *Time* | |
| Name | | | |
| Birth Year | | | |

Gender male female other

**In an effort to provide you the safest possible sleeping and living conditions, we want to screen you for symptoms of COVID-19. We will help you have a safe place to stay regardless of COVID-19 risk or not.**

**A. Please perform hand hygiene with hand sanitizer (if supplies allow) and answer these questions**

**B. MEASURED TEMPERATURE** C F

**C. Over the past 14 days, have you had ANY of these symptoms?**

| | | YES | NO | DID NOT ANSWER |
|---|---|---|---|---|
| 1 | Dry cough (change from baseline) | | | |
| 2 | Shortness of breath (change from baseline) | | | |
| 3 | Muscle aches (myalgias) | | | |
| 4 | Sore throat | | | |
| 5 | Headache *(influenza like illness)* | | | |
| 6 | Fatigue *(influenza like illness)* | | | |
| 7 | Have you had close contact with anyone who has COVID-19? (close contact is defined as <6ft for >10 minutes) | | | |

If yes to 1-7 with T>37.8 please apply 3-layer mask and direct to isolation area; if yes to any questions 1-4 without T>37.8 (100F) or T>37.8 without symptoms please direct to health care on duty

**Work flow**:
A.Name collected by line monitor(s); B) 2-person team to collect info (one to ask questions, one as recorder; C. Third person taking temperature; D) Sticker given at conclusion

**Notes:**