INITIAL SCREENING QUESTIONNAIRE

IMPORTANT: THE SCREENER SHOULD IMMEDIATELY STOP THE SCREENING AND DENY ACCESS TO ANY INDIVIDUAL WHO ANSWERS YES TO ANY SCREENING QUESTION.

For infection control purposes, I need to ask you a few questions:	
Have you had any of the following symptoms in the last seven days: fever or chills, cough, sore throat, shortness of breath, nausea, vomiting, diarrhea or any other flu-like symptoms, headache or unusual muscle pain, loss of taste or smell?	☐ Yes ☐ No
In the past week, do you know if you have been in close (less than 6 feet), prolonged contact (more than 15 minutes) with someone with a fever, cough, shortness of breath, nausea, vomiting, diarrhea, flu-like symptoms, or a diagnosis of COVID 19?	☐ Yes ☐ No
Have you had a positive test for COVID-19 infection within the past fourteen (14) days?	☐ Yes ☐ No

Individuals who answer YES to ANY question on the Initial Screening Questionnaire OR refuse to participate in the screening process <u>must</u> be denied access to the facility.

Name (printed)____

Phone number____

Temperature __________________________________

Access Determination ______Approved ________Denied

Name of staff completing form____________________________Date________Time ______
(Please print)

Rev. 6/9/2020

ENGLISH	SPANISH
INITIAL SCREENING QUESTIONNAIRE	CUESTIONARIO DE EVALUACIÓN INICIAL
IMPORTANT: THE SCREENER SHOULD IMMEDIATELY STOP THE SCREENING AND DENY ACCESS TO ANY INDIVIDUAL WHO ANSWERS YES, TO ANY SCREENING QUESTION.	IMPORTANTE: EL EVALUADOR DEBE SUSPENDER INMEDIATAMENTE LA EVALUACIÓN Y NEGAR EL ACCESO A CUALQUIER INDIVIDUO QUE RESPONDA SÍ A CUALQUIER PREGUNTA DEL CUESTIONARIO.
For infection control purposes, I need to ask you a few questions:	Para fines de controlar infecciones, necesito hacerle algunas preguntas:
Have you had any of the following symptoms in the last seven days: fever or chills, cough, sore throat, shortness of breath, nausea, vomiting, diarrhea or any other flu-like symptoms, headache or unusual muscle pain, loss of taste or smell? ___Yes ___No	¿Ha tenido alguno de los siguientes síntomas en los últimos siete días: fiebre o escalofríos, tos, dolor de garganta, falta de aliento, ¿náuseas, vómitos, diarrea u otros síntomas similares a los de la gripe, dolor de cabeza, o dolor muscular inusual, la pérdida del sentido del gusto o del olfato? ___Si ___No
In the past week, do you know if you have been in close (less than 6 feet), prolonged contact (more than 15 minutes) with someone with a fever, cough, shortness of breath, nausea, vomiting, diarrhea, flu-like symptoms, or a diagnosis of COVID 19?	En la última semana, ¿sabe si ha estado en contacto cercano (menos de 6 pies), prolongado (más de 15 minutos) con alguien con fiebre, tos, falta de aliento, náuseas, vómitos, diarrea, síntomas similares a los de la gripe o con un diagnóstico de COVID 19?
Have you had a positive test for COVID-19 infection within the past fourteen (14) days?	¿Ha tenido una prueba positiva por la infección de COVID-19 en los últimos catorce (14) días?

Individuals who answer YES to ANY question on the Initial Screening Questionnaire OR refuse to participate in the screening process must be denied access to the facility.	Individuos que responden SÍ a CUALQUIER pregunta de la evaluación inicial O se niegan a participar en el proceso de evaluación, se les <u>debe</u> negar el acceso al edificio.
Name of Individual Seeking Access ___________________ (please print)	Nombre del individuo que solicita el acceso ___________________ (en letra de imprenta)
Temperature of Individual Seeking Access __________	Temperatura del individuo que solicita el acceso__________
Access Determination	Determinación sobre el acceso
___ Approved ____Denied	_____ Aprobado _____Negado
Name of staff completing form ____________ _ Date: ____ Time: ___ _ (Please print)	Nombre del personal que completa el formulario ____________ _ Fecha: ____ Hora: ___ _ (en letra de imprenta)