COVID-19 Self-Screening Tool

To be completed daily, prior to any clinical experience

Student / Faculty Name: ____________________

Date: __________ Campus: __________ Clinical Site: __________

1. **Do you have a fever?** *Yes* *No* Current Temperature __________

2. Are you experiencing any Symptoms:

   a. **Do you have a cough?** *Yes* *No*

   b. **Are you Short of Breath?** *Yes* *No*

   If yes:

   When did symptoms begin? ____________________

   Have you been in contact with a healthcare provider? ____________________

   Details: ____________________

   ____

3. **Have you traveled in the past 14 days?** *Yes* *No*

   If yes:

   Where? ____________________

   When? ____________________

4. **Have you been in contact with anyone who has been diagnosed with COVID-19?** *Yes* *No*

   If yes, describe contact and when: ____________________

   ____

5. **Have you been in contact with anyone that has had a cough, SOB or a fever in the past 14 days?** *Yes* *No*

   If Yes, details: ____________________