Name_____________________________ DOB _______________

Screening Questions for COVID Testing

Have you been sent for COVID testing by your employer or School?

YES/Name: ____________________________ NO__________

If you answered "YES" is your employer paying for the test?

YES_________ NO_________

If you answered ""YES" to both questions, you will need to be tested at the Occupational Health Department in the clinic.

Has the Health Department contacted as a contract traced exposure?

YES ________ NO__________ Which county? __________________________

Do you have any symptoms?

Yes ________ NO__________

What are your symptoms?

_____ FEVER OR CHILLS

_____ COUGH

_____SHORTNESS OF BREATH OR DIFFICULTY BREATHING

_____FATIGUE

_____ MUSCLE OR BODY ACHES

_____HEADACHE

_____NEW LOSS OF TASTE OR SMELL

_____ SORE THROAT

_____CONGESTION OR RUNNY NOSE

_____NAUSEA OR VOMITING

_____OTHER DESCRIBE____

When did your symptoms first start? ____________________________

Are you aware of being exposed to a COVID positive person?

YES__________ NO________________

Name of Person_____________________________ County of residence _______________________

(**Close contact exposure is defined as being within 6 ft. of someone with COVID for more than 15 minutes)**

Is that exposure living in your same household?

YES_________ NO___________