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: _____

_____