DUMONT COVID-19 Daily Pre-screening Questions

Name:_____ **Date: _____**

Phone #: _____ **School/Building/Position: _____**

Any of the symptoms below could indicate a COVID-19 infection and may put you at risk for spreading illness to others. This list does not include all possible symptoms and it should be noted that individuals with COVID-19 may experience any, all, or none of these symptoms. You must check yourself daily for these symptoms and you must answer yes or not to each symptom listed. If you answer YES to any of these symptoms, please do not report

Symptoms	**Please Circle One**	
1. Fever (≥ 100.4°F)	**YES**	**NO**
2. Cough, shortness of breath, or difficulty breathing	**YES**	**NO**
3. Sore Throat	**YES**	**NO**
4. Chills	**YES**	**NO**
5. Muscle aches (myalgia)	**YES**	**NO**
6. Rigors (shivers)	**YES**	**NO**
7. Fatigue (extreme tiredness)	**YES**	**NO**
8. Headache	**YES**	**NO**
9. Congestion or Runny Nose	**YES**	**NO**
10. New loss of taste or smell	**YES**	**NO**
11. Abdominal pain, nausea, vomiting or diarrhea	**YES**	**NO**
12. Have you had close contact (within 6 feet of an infected person for 15 or more minutes during a 24-hour period) with a person who is sick?	**YES**	**NO**
13. Have you had close contact (within 6 feet of an infected person for 15 or more minutes during a 24-hour period) with a person with COVID-19 in the last 14 days?	**YES**	**NO**
14. In the last 14 days, has someone in your household been diagnosed with or is being tested for COVID-19?	**YES**	**NO**
15. Have you traveled to a state or area with high community transmission in the last 14 days?	**YES**	**NO**
16. Did you take any fever reducing medicine this morning?	**YES**	**NO**

17. What is your temperature this morning? _____

I certify that the responses I provided to the questions above are all true.

Individual's Signature:_____ Rev 12/2/20