

**Daily Pre-Screening**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please complete this pre-screening form before beginning your class today.

*Circle the correct answer*.

1. I am a \_\_\_\_\_?

1. Student B. Faculty/Staff member

2. Do you have any of the following symptoms?

A: Fever

B: New onset of cough

C: Worsening chronic cough

D: Shortness of breath

E: Difficulty breathing

F. Sore throat

G. Difficulty swallowing

H. Decrease or loss of sense of taste or smell

I. Headaches

3. Have you traveled outside of the country in the last 14 days?

A. Yes B. No