

**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 or worsening cough

C: Shortness of breath

E: Difficulty breathing

F. Sore throat

G. Difficulty Swallowing

H. Decrease or loss of sense of taste or smell

F. No symptoms

3. Have you been in close contact with anyone who has been diagnosed with COVID-19 in the last 14 days?

 A. Yes B. No

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