NTC COVID-19 DAILY SCREENING

Accessible version available at nursingtrainingcenter.com

STUDENT NAME:_____TODAY'S DATE:_____

TEMPERATURE:_____ VERIFIED BY:_____

PLEASE READ EACH QUESTION CAREFEULLY **PLEASE CIRCLE THE ANSWER THAT APPLIES TO YOU**

Have you experienced any of the following symptoms in the last 48 hrs:

*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
*diarrhea

YES NO

Within the past 14 days, have you been in close physical contact (6 feet or closer for At least 15 minutes) with a person who is known to have laboratory-confirmed COVID-19 or with anyone who has any symptoms consistent with COVID-19? YES NO

Are you isolating or quarantining because you may have been exposed to a person with COVID-19 or are worried that you may be sick with COVID-19? YES NO

Are you currently waiting on the results of a COVID-19 test? YES NO

Did you answer **NO** to **ALL QUESTIONS**? Access to NTC APPROVED. THANK YOU FOR HELPING US PROTECT YOU AND OTHERS DURING THIS TIME.

Did you answer **YES** to **ANY QUESTIONS**? Access to NTC NOT APPROVED. Please see Page 2 for further instructions. Thank you for helping us protect you and others.