Hands on Relief Covid-19 Health Screening

For the safety of Hands on Relief and clients, please answer the following questions.

1. Please indicate if you have any of the following symptoms today or within the last 14 days:
   ___Shortness of breath
   ___Fever
   ___Cough
   ___Chills
   ___Sore throat

2. Have you been around anyone with these symptoms in the last 14 days?
   ___Yes
   ___No

3. Have you traveled domestically or internationally within the last 4 weeks?
   ___Yes
   ___No

4. Have you successfully followed the CDC guidelines for social distancing?
   ___Yes
   ___No

Name: _____ Date: _____

Signature: _____