Health Screening Form

NAME: ______________________________________ **DATE:** ___________

1. **Do you currently have a fever of 100.4 degrees F or greater?**
   ☐ No. Go to the next question. ☐ Yes. No further screening is needed. Entry is not permitted.

2. **Have you had any of these symptoms in past 14 days?**
   - Fever or chills
   - Cough
   - Shortness of breath or difficulty breathing
   - Muscle or body aches
   - New loss of taste or smell
   - Nausea or vomiting
   - Diarrhea

   ☐ No. Go to the next question.
   ☐ Yes. No further screening is needed. Entry is not permitted.

Temperature
____

3. **Have you been in contact with a person who has COVID-19 in the past 14 days?**
   ☐ No.
   ☐ Yes. No further screening is needed. Entry is not permitted.

4. **Have you had a positive COVID -19 test in the past 14 days?**
   ☐ No.
   ☐ Yes. No further screening is needed. Entry is not permitted.

5. **Have you or a household family member left New York State in the past 14 days?**
   ☐ No.
   ☐ Yes. Where? _____________ Reason? ________________ Entry may not permitted.

I agree that all answers above are accurate and truthful:

Signature : ____ Date: _____________

https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html