COVID SCREENING QUESTIONS

TEMPERATURE		
Is your temperature greater than or equal to 100.0 degrees Fahrenheit?	☐ YES	☐ NO

CONTACTS		
Have you had any known close contact with a person confirmed or suspected to have COVID-19 in the past 14 days?	☐ YES	☐ NO

SYMPTOMS		
Are you currently experiencing ANY of the following symptoms?		
Cough (new or worsening)	☐ YES	☐ NO
Shortness of Breath (new or worsening)		
Troubled Breathing (new or worsening)		
Fever		
Chills		
Muscle Pain (new or worsening)		
Headache (new or worsening)		
Sore Throat (new or worsening)		
New Loss of Taste		
New Loss of Smell		

POSITIVE TEST RESULT		
Have you tested positive for COVID-19 through a diagnostic test in the past 14 days?	☐ YES	☐ NO

OUT OF STATE TRAVEL		
Have you traveled within a state **that does not border New York State**, or **stayed longer than 24 hours within the past 14 days?**	☐ YES	☐ NO
Exception: I have "tested out" per CDC Guidelines or have been designated as an essential employee, per CDC Guidelines?	☐ YES	

NOTE:

If you answer "Yes" to any of the above questions, with the exception of the last question you will not be permitted entry and referred to a Supervisor.

If you answer "No" to all of the questions, you will be instructed to proceed to the next screening area.

For the protection of everyone, all persons entering MUST wear a FACE MASK

NEW YORK STATE | Office of Children and Family Services

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