Guidelines for Classroom Training – Survey

Date:_____ Unit/Training:_____

Name:_____

COVID SCREENING SURVEY		
PLEASE READ EACH QUESTION CAREFULLY	**CIRCLE APPROPRIATE ANSWER**	
Have you experienced any of the following symptoms in the past 48 hours: • fever (100.4 or greater) or chills • cough • shortness of breath or difficulty breathing • fatigue • muscle or body aches (not from recent exercise/activity) • 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?	Proceed to training. Notify instructor for any status changes to above questions	
Did you answer **YES** to **ANY** questions?	STOP! Training is not authorized. Contact immediate supervisor for disposition and medical assessment recommendations.	