COVID-19 SCREENING FORM

PLEASE CHECK ANY SYMPTOMS YOU ARE CURRENTLY EXPERIENCING:

- ☐ Temperature of 100.4° F or greater
- ☐ Headache
- ☐ Sore throat
- ☐ Congestion
- ☐ Runny nose
- ☐ Tightness in chest
- ☐ Loss of smell or taste
- ☐ Nausea or vomiting

TEMPERATURE READING: _____

- ☐ Fatigue
- ☐ Cough
- ☐ Sneezing
- ☐ Shortness of breath
- ☐ Muscle or body aches
- ☐ Diarrhea

Notes: _____

_____

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☐ Yes ☐ No Have you had a recent exposure (in the past 10 days)?

If yes, ☐ I have contacted a member of management regarding my exposure and have been approved to report to work.

☐ Yes ☐ No I have been tested outside of Sun Health in the last 14 days.
If yes, ☐ I have informed a member of management.

Sun Health Team Members: Please notify your supervisor if you are symptomatic.

_____
NAME [please print]

_____
SIGNATURE JOB TITLE

_____
REASON FOR VISIT / RESIDENT ROOM DATE TIME

During the COVID-19 pandemic, this questionnaire is part of safety measures as recommended by our local and state health department, the CDC and CMS to protect the health and safety of the staff and residents. This screening form will be stored in a secure location. By signing this form, I affirm my answers to these questions are accurate and true. If it is discovered that I falsified these answers, I can be subject to disciplinary action up to and including termination.

_____

To be completed by screener:

My initials indicate that I have reviewed this form for any COVID concerns.

Screener Initials (Please Print): _____

Sun Health®
Revised 2/02/2022