COVID-19 Daily Assessment Tool

COVID-19 Daily Assessment Tool

Senior Center: _____ County:_____ Date: _____

Do you have a Fever (temperature over 100.4F) without having taken any fever reducing medications?	Yes No
Do you have a recent Loss of Smell or Taste?	Yes No
Do you have a Cough?	Yes No
Do you have Muscle Aches?	Yes No
Do you have a Sore Throat?	Yes No
Do you have Shortness of Breath?	Yes No
Do you have Chills?	Yes No
Do you have a Headache?	Yes No
Do you have Congestion or a Runny Nose?	Yes No
Do you have Fatigue?	Yes No
Have you experienced any gastrointestinal symptoms such as nausea/vomiting, diarrhea, loss of appetite?	Yes No
Have you, or anyone you have been in close contact with (*within 6 feet of an infected person for a cumulative total of 15 minutes or more over a 24-hour period*) been diagnosed with COVID-19, or been quarantined for possible contact with COVID-19?	Yes No
Have you been asked to self-isolate or quarantine by a medical professional or a local public health official?	Yes No
Are you currently awaiting the results of a COVID-19 test?	Yes No
If you reply YES to any of the questions on this checklist, you will not be allowed to enter the Senior Center today.	

Senior Center Sign-in Sheet

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Senior Center: _____ **County:** _____ **Date:** _____

My signature below confirms that I completed the COVID-19 Daily Assessment Tool today and answered **NO** to all questions.

Name	Telephone Number

****Please make appropriate copies, use an individual page per participant, and store in a secure location to ensure the participant's privacy.*