Wellness Check for ________________________ Date ________________

Best contact # ____________________________ Screened by __________

Have you or any household member had any of these symptoms, **not attributable to another condition**, within the last 14 days**?**

Fever or chills	Y	N
Cough	Y	N
Shortness of breath/difficulty breathing	Y	N
Fatigue	Y	N
Muscle or body aches	Y	N
New loss of taste or smell	Y	N
Congestion or runny nose	Y	N
Nausea or vomiting	Y	N

Have you taken your temperature today? Y N

If so, what was the reading? ______________

Have you or any household member had close contact with someone known or suspected to have COVID-19? Y N

Are you or any household member awaiting a COVID-19 test result? Y N

Wellness Check for ________________________ Date ________________

Best contact # ____________________________ Screened by __________

Have you or any household member had any of these symptoms, **not attributable to another condition**, within the last 14 days**?**

Fever or chills	Y	N
Cough	Y	N
Shortness of breath/difficulty breathing	Y	N
Fatigue	Y	N
Muscle or body aches	Y	N
New loss of taste or smell	Y	N
Congestion or runny nose	Y	N
Nausea or vomiting	Y	N

Have you taken your temperature today? Y N

If so, what was the reading? ______________

Have you or any household member had close contact with someone known or suspected to have COVID-19? Y N

Are you or any household member awaiting a COVID-19 test result? Y N

Wellness Check for ________________________ Date ________________

Best contact # ____________________________ Screened by __________

Have you or any household member had any of these symptoms, **not attributable to another condition**, within the last 14 days**?**

Fever or chills	Y	N
Cough	Y	N
Shortness of breath/difficulty breathing	Y	N
Fatigue	Y	N
Muscle or body aches	Y	N
New loss of taste or smell	Y	N
Congestion or runny nose	Y	N
Nausea or vomiting	Y	N

Have you taken your temperature today? Y N

If so, what was the reading? ______________

Have you or any household member had close contact with someone known or suspected to have COVID-19? Y N

Are you or any household member awaiting a COVID-19 test result? Y N

Wellness Check for ________________________ Date ________________

Best contact # ____________________________ Screened by __________

Have you or any household member had any of these symptoms, **not attributable to another condition**, within the last 14 days**?**

Fever or chills	Y	N
Cough	Y	N
Shortness of breath/difficulty breathing	Y	N
Fatigue	Y	N
Muscle or body aches	Y	N
New loss of taste or smell	Y	N
Congestion or runny nose	Y	N
Nausea or vomiting	Y	N

Have you taken your temperature today? Y N

If so, what was the reading? ______________

Have you or any household member had close contact with someone known or suspected to have COVID-19? Y N

Are you or any household member awaiting a COVID-19 test result? Y N