# COVID-19 Screening Form

**Purpose:** This form is intended to help healthcare providers screen individuals for symptoms or exposure related to COVID-19 prior to receiving care. Please complete all sections accurately to help ensure the safety of staff and patients.

## Participant Information

* **Full Name:** {fullName}
* **Date of Birth:** {dateOfBirth}
* **Phone Number:** {phoneNumber}
* **Email Address:** {email}
* **Date of Screening:** {screeningDate}

## Symptoms Checklist

Have you experienced any of the following symptoms in the past 14 days?

{#symptoms}

* {symptom}

{/symptoms}

Note: Symptoms may include fever, cough, shortness of breath, fatigue, muscle/body aches, loss of taste or smell, sore throat, congestion, nausea, or diarrhea.

## Exposure History

* **Have you tested positive for COVID-19 in the past 14 days?** {testedPositive}
* **Have you had close contact with someone who has tested positive for COVID-19 in the past 14 days?** {hadContact}

## Vaccination Information

* **Have you been vaccinated against COVID-19?**
* {#isVaccinated}
	+ **Date of Last Dose:** {lastDoseDate}
	+ **Vaccine Type:** {vaccineType}
* {/isVaccinated}

## Travel History

* **Have you traveled internationally in the last 14 days?**
* {#internationalTravel}
	+ **Country Visited:** {countryVisited}
	+ **Return Date:** {returnDate}
* {/internationalTravel}

## Screening Outcome

**Result:** {screeningResult}

{#recommendations}

* {recommendationText}

{/recommendations}

## Signature

**Name of Screener:** {screenerName}

**Signature:** {screenerSignature}

**Date:** {signatureDate}