



COLORADO

Department of Human Services

COVID19 SCREENING QUESTIONS

Staff, Visitors

Name: _____

Date: _____ **Time:** _____

Screening Employee: _____

Do you have:

Fever within past 24 hours:	Yes _____	No _____
Coughing/Sneezing	Yes _____	No _____
Sore throat	Yes _____	No _____
Shortness of breath	Yes _____	No _____

And/or the following within the past 14 days:

Recent Travel	Yes _____	No _____
to high risk areas		
Exposure to someone	Yes _____	No _____
with documented or suspected		
COVID-19		
Resides in a community where		
community-based spread of COVID-19		
is occurring	Yes _____	No _____

If staff or visitors answer yes to any of these questions, do not allow them into your facility. Follow your facility's protocols for what to do next. (A review by medical personnel should be available for questionable situations.)

Please contact your supervisor if needed for additional guidance.

**All completed forms must be saved.*