GUEST CHECK-IN ASSESSMENT

NAME _____ DATE _____ TIME _____

Temperature: _____DATE_____TIME_____

Completed by staff member: _____

PASSED ASSESSMENT/MAY ENTER: YES NO

If you answer YES to any questions or make a check next to the symptom and immediately inform management. You may be asked to go home or instructed to go into isolation.

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1. **Are you feeling ill? YES NO I DON'T KNOW**

2. People with COVID-19 have had a wide range of symptoms reported – ranging from mild symptoms to severe illness. Symptoms may appear 2-14 days after exposure to the virus. People with these symptoms may have COVID-19. Do you have any of these symptoms:

   Do you have any of these symptoms? Check those that apply.

- Fever or chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

3. Have you, or has anyone in your family or close connections Work for example), come in contact with anyone diagnosed with COVID 19 within the past 14 days?

YES NO

4. Have you, or anyone in your family, travelled out of the country or to an area of the USA with a current hot spot of COVID 19

YES NO