**Hudson Senior Center Covid-19 Screening**

DATE: TIME: NAME:

Check all that applies below

Transportation request Appointment request at center Both

* Have you or anyone in your household had any of the following symptoms in the last 14 days:
* Sore throat
* Cough: (Not related to chronic condition)
* New nasal congestion or New runny nose (not related to seasonal allergies)
* Body aches or chills
* Shortness of breath or other respiratory problem
* Loss of smell or taste
* Fever at or greater than 100 degrees Fahrenheit
* New sinus pain/pressure
* Diarrhea
* Have you or anyone in your household tested positive for COVID-19? **YES NO**
* Have you or anyone in your household visited or received treatment in a hospital, nursing home, long-term care, or other health care facility in the past 14 days? **YES NO**
* Have you or anyone in your household traveled in or out of the U.S. in the past 14 days?

**YES NO**

* Have you or anyone in your household cared for an individual who is in quarantine or has tested positive for COVID-19? **YES NO**
* Do you have any reason to believe you or anyone in your household has been exposed to or acquired COVID-19? **YES NO**

*Signature of screener:*