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 to high risk areas	Yes _____	No _____
Exposure to someone with documented or suspected COVID-19	Yes _____	No _____
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.*

3.11.20