Gila River Indian Community

COVID-19 HEALTH SCREENING QUESTIONNAIRE

All individuals will be screened prior to entering the facility/establishment to ensure the health and well-being of the Community.

Name: _____

1. Are you experiencing any of these symptoms:

	Yes	No		Yes	No
New/worsening cough	☐	☐	Congestion or runny nose	☐	☐
Shortness of breath	☐	☐	Loss of smell or taste	☐	☐
Fever or headache	☐	☐	Fatigue	☐	☐
New onset chills or shaking with chills	☐	☐	New onset diarrhea	☐	☐
			New onset muscle or body aches/pain	☐	☐

2. Have you had close contact with anyone who has tested positive for Coronavirus (COVID-19) within the past two weeks (14 days)? ☐ ☐

3. Has anyone in your household tested positive for Coronavirus (COVID-19) within the past two weeks (14 days) and is currently under isolation? ☐ ☐

4. Have you or anyone in your household traveled within the last two weeks? ☐ ☐

5. Current Temperature: _____

I have truthfully answered the above questions.

Print Name: _____

Signature: _____ Date: _____

- If the individual answered yes to anyof the questions or has fever, the person should not enter the facility and instructed to call their primary care provider or local health department to obtain further instructions.