Test Preps COVID-19 Screening Form

Name of Student or Tutor ____ Date _______________________

Temperature upon arrival ________

1) Are you experiencing any COVID-19 symptoms? Symptoms may include (but are not limited to):

Fever/chills	Muscle or body aches	Headache
Cough	Fatigue	Sore throat
Difficulty breathing/shortness of breath	Loss of taste or smell	Nausea/Vomiting/Diarrhea

Yes ______ No _______

2) Have you been in direct contact with any person confirmed positive for COVID-19 in the past 14 days?

Yes ______ No _______

Signature ____

Test Preps COVID-19 Screening Form

Name of Student or Tutor ____ Date _______________________

Temperature upon arrival ________

1) Are you experiencing any COVID-19 symptoms? Symptoms may include (but are not limited to):

Fever/chills	Muscle or body aches	Headache
Cough	Fatigue	Sore throat
Difficulty breathing/shortness of breath	Loss of taste or smell	Nausea/Vomiting/Diarrhea

Yes ______ No _______

2) Have you been in direct contact with any person confirmed positive for COVID-19 in the past 14 days?

Yes ______ No _______

Signature ____

Test Preps COVID-19 Screening Form

Name of Student or Tutor ____ Date _______________________

Temperature upon arrival ________

1) Are you experiencing any COVID-19 symptoms? Symptoms may include (but are not limited to):

Fever/chills	Muscle or body aches	Headache
Cough	Fatigue	Sore throat
Difficulty breathing/shortness of breath	Loss of taste or smell	Nausea/Vomiting/Diarrhea

Yes ______ No _______

2) Have you been in direct contact with any person confirmed positive for COVID-19 in the past 14 days?

Yes ______ No _______

Signature ____