GENEVA FAMILY YMCA COVID-19 STAFF, MEMBERS, VENDOR SCREENING FORM

Date:_____

Name:_____

Address:_____

Phone #:_____

Email :_____

Please Circle:

Employee **Member** **Other**

The following questions should be asked of all individuals entering the facility.
QUESTIONS SHOULD BE ASKED IN PRIVATE & ANSWERS ARE CONFIDENTIAL.

Have you traveled outside of the state or country within the past 14 days?

_____YES _____ NO

If so, where have you traveled? _____
What was your date of return? _____

Have you, or anyone in your family, come into close contact (within 6 feet) with someone who has a suspected or confirmed COVID-19 diagnosis in the past 14 days either at home or on a jobsite etc.?

_____YES _____ NO

Have you had a fever (greater than 100.4 or 38.0C) OR symptoms of lower respiratory illness such as cough, shortness of breath, or difficulty breathing in the past 14 days?

_____ YES _____ NO

Are you currently experiencing a fever (greater that 100.4 F or 38.0 C) OR symptoms of lower respiratory illness such as cough, shortness of breath, or difficulty breathing?

_____ YES _____ NO

NOTE: If an individual answers 'YES' to any of the above questions, ask them to leave the facility immediately and seek medical evaluation.

Place this form in HEALTH SCREENING BINDER

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