

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

Date: \_\_\_\_\_  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone #: \_\_\_\_\_  
Email : \_\_\_\_\_

**Please Circle:**

<b>Employee</b>	<b>Member</b>	<b>Other</b>
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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 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 than 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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