

COVID-19 Screening Questionnaire

NAME: _____ Date: _____

SNCOA FLIGHT #:

Q1: Have you traveled internationally/been on a cruise in the past 14 days? Yes ___ No ___

Q2: Have you been in contact with a positive, confirmed COVID-19 patient? Yes ___ No ___

Q2a. If yes, date of last contact _____

Q3: Have you tested positive for COVID-19 within the last 90 days? Yes ___ No ___

Q4: Do you have fever/chills, cough, shortness of breath, sore throat, body aches, decreased smell/taste, or other respiratory symptoms? Yes ___ No ___

Q3a. If yes, date cleared by primary care physician _____

Q5: Have you taken Motrin, Tylenol or Aspirin in the last 6 hours? Yes ___ No ___

Q4a. If yes, contact your primary instructor.

Q6: Point of origin for travel to Maxwell: _____

Q7: Any significant stop-overs in transit to Maxwell (not including flight lay-overs)? _____ Yes ___ No ___

TEMP: _____