PORT ANGELES SCHOOL DISTRICT

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COVID-19 SCREENING FORM –STAFF/VISITORS

Please complete this form to assess your potential exposure to or diagnosis of COVID-19 or other illnesses.

Name: _____ Date: _____

Question	YES	NO
Have you been in close contact with anyone with confirmed COVID-19?		
Have you had a positive COVID-19 test for active virus in the past 10 days?		
Within 14 days, has a public health or medical professional told you to self-monitor, self-isolate, or self-quarantine because of concerns about COVID-19?		
Have you had any of the following symptoms that are not caused by another condition in the past 72 hours?		
• Fever (100.4) or chills		
• Cough		
• Shortness of breath or difficulty breathing		
• Unusual Fatigue		
• Muscle or body aches		
• Headache		
• Recent loss of taste or smell		
• Sore Throat		
• Congestion or runny nose		
• Nausea, vomiting, or diarrhea		

If you answered yes to any of the above questions, then we kindly ask that you do not enter any PASD building. Please talk with your supervisor to further discuss your individual situation.

Signature: _____