

COVID-19 Client Screening Questionnaire

** indicates a required field*

*** Client's Name:**

*** I attest that the person named above has not traveled out of state in the last 24 hours. JFS follows the NYS COVID Travel Advisory. Updated travel and testing information can be found on NYS's travel advisory page. <https://coronavirus.health.ny.gov/covid-19-travel-advisory> ***

☐ Yes

☐ No

Symptom Check

Please check all symptoms that apply. If client does not have any of the symptoms below, please select - None. *

☐ None

☐ Fever of 100.4 degrees F that is not reduced by taking fever reducing medication

☐ Cough

☐ Sore throat

☐ Chills

☐ Loss of taste or smell

☐ Headache

☐ Gastrointestinal issues - Nausea, vomiting, diarrhea, loss of appetite

☐ Shortness of breath

☐ Muscle aches

*** Has the person named above or anyone in their household been in close contact with or been diagnosed with COVID-19 or been placed on quarantine for possible contact with COVID-19? ***

☐ Yes

☐ No