

Philadelphia Department of Public Health

COVID-19 Screening Tool

Date: _____

Name: _____

1. **TEMPERATURE:** _____ °F Temperature taken on-site Temperature taken at home

IF temperature 100.4°F or higher → do not allow into the facility

2. SYMPTOMS

Do you have any of the following?

Cough

Shortness of breath

If YES to either → do not allow into the facility

OR

Fever

Sore throat

If YES to 2 or more → do not allow into the facility

Chills

Muscle pain

Headache

New loss of taste or smell

3. VISUAL INSPECTION

Does the individual have flushed cheeks, rapid breathing or difficulty breathing (without recent physical activity), fatigue, or extreme fussiness (in a child), or cough?

Yes

No

Comments:

If YES → do not allow into the facility

4. EXPOSURE

Have you been exposed to anyone with a confirmed case of COVID-19 in the past 14 days?

Yes

No

Comments:

If YES → do not allow into the facility