

# 2020-2021 WAMC COVID-19 IMMUNIZATION DRIVE

## PRE-SCREENING FORM

- This form must be complete before checking in to the immunization drive
- If you answer yes to any question please inform the screener. You will be further evaluated by a medical team member

|  | YES | NO |
|--|-----|----|
| 1. Have you had a fever in the last 24 hours?  |     |    |
| 2. Have you had a new or worsening cough in the last 3 days?   |     |    |
| 3. Do you have nasal congestion, runny nose, loss of taste or smell, or feel ill in any way?                     |     |    |
| 4. Have you had exposure to someone confirmed positive with covid-19 while not wearing PPE?<br>If yes, answer #5 |     |    |
| 5. If you were exposed, did you complete quarantine or isolation within the last 30 days?                        |     |    |

SIGNATURE \_\_\_\_\_

PRINT NAME \_\_\_\_\_

DEPARTMENT \_\_\_\_\_

DATE \_\_\_\_\_