TCC COVID-19 HEALTH SCREENING

NAME	**Date**	
1. Are you experiencing or have you experienced any of the following symptoms **in the last 7 days**:	**N0**	**YES**
2. **FEVER**- temp. equal or greater than 100.4 F		
3. **CHILLS** with shaking or teeth chattering		
4. SORE THROAT		
5. Frequent **COUGH**		
6. **Shortness of breath** at rest		
7. Pain or tightness in chest		
8. Flu-like symptoms		
9. **Muscle Pain** unrelated to exercise		
10. Loss of ability to taste or smell		
11. Do you live with someone who is sick at home with bronchitis-like or cold symptoms?		
12. Have you recently **tested positive for COVID-19?**		
13. If yes, **date of test**.		
14. Have you had interaction with **anyone in the last two weeks who has tested positive for COVID-19?**		
15. Are you or a member of your household **awaiting COVID-19 test results?**		
16. Have you or a member of your household been **asked to self-isolate?**		
*17. Have you or a member of your household **traveled outside of NJ in the last 2 weeks**?*		
*18. If yes, **where?***		
TCC Volunteer Initials-		

*If someone answers yes to **Questions #1-16**, they should be asked to return home with a recommendation to call their doctor.*

*If someone answers yes to **Questions 17-18**, please call Scott, Jim C., Stan, Don K., Jim R., or Jennifer for further instructions.*

*These questions have been **recommended by the Metro CMA District** and derived from guidance crafted on May 1, 2020 by The Attending Physician for the US Congress.*