COVID Screening Roster

Date/Time Period_____ **OIC:**_____

NAME	DATE	TIME	Tempurature *(>100.4 F)*	SHORTNESS OF BREATH *(Y OR N)*	COUGH *(Y OR N)*	Productive? (Y OR N)	Sore Throat? (Y OR N)	Home or Moderate Risk Exposure	CLEAR FOR DUTY	Medical Referral: Positive	Screened By