COVID-19 Screening Questionnaire

Check-In Date:_____ Check-Out Date:_____

Please print the name of the guest(s) staying in the room below:

1. Guest Name (Print): _____
2. Guest Name (Print): _____
3. Guest Name (Print): _____
4. Guest Name (Print): _____

Temperature		
Sec. Officer Employee #:		
Official Use Only	**1**	
	2	
	3	
	4	

Please answer questions below for each guest listed above:

1. Does any person listed above have a new cough that they cannot attribute to another health condition?	☐ YES	☐ NO
2. Does any person listed above have a new shortness of breath that they cannot attribute to another health condition?	☐ YES	☐ NO
3. Does any person listed above have any two of the following symptoms: Fever (100.4° F or higher), chills, repeated shaking with chills, muscle pain, headache, sore throat, or new loss of taste or smell?	☐ YES	☐ NO
4. Has any person listed above come into close contact (within 6 feet) with someone who has a laboratory-confirmed COVID-19 diagnosis in the past 14 days?	☐ YES	☐ NO

By printing the names above, I (we) acknowledge and understood the above questions and have answered them truthfully to the best of my (our) knowledge. I (we) give consent to Security conducting temperature check for fever at the Front Desk. I (we) also acknowledge, if any person traveling with our group develops any symptoms during our stay, I (we) will notify the Front Desk or Security.

Front Desk	
Room #:	