THRIVE DAILY SCREENING SURVEY

Today's Date:_____

First Name : _____Last Name : _____

SYMPTOMS

1. Check if you have these symptoms:

☐ Congestion or Runny Nose	☐ Chills	☐ Rigors (shivers)
☐ Myalgia (muscle aches)	☐ Headache	☐ Sore Throat
☐ Nausea or Vomiting	☐ Diarrhea	☐ Fatigue
☐ Fever (less than 100.4° F measured and verified)		

2. Did you check **TWO OR MORE** in question 1?

☐ **Yes** – You are NOT CLEARED TO COME IN TODAY	☐ **No –** GO TO QUESTION 3

3. Check if you have any of these symptoms:

☐ Cough	☐ Shortness of Breath	☐ Difficulty breathing
☐ New loss of smell	☐ New loss of taste	

4. Did you check **ONE** in Question 3?

☐ **Yes** – You are NOT CLEARED TO COME IN TODAY	☐ **No** – Complete the next section.

CLOSE CONTACT/POTENTIAL EXPOSURE

5. Did you have close contact **(within 6 feet of an infected person for at least 15 minutes within a 24- hour period)** with a person with confirmed COVID – 19?

☐ **Yes** – You are welcome to come to program, but must wear a well-fitted mask for 10 days as long as you are asymptomatic.	☐ **No** – GO TO QUESTION 6.

6. Is someone in your household diagnosed with COVID – 19?

☐ **Yes** – You are welcome to come to program, but must wear a well-fitted mask for 10 days as long as you are asymptomatic.	☐ **No -** You are welcome to attend the program today. See you soon!

Person completing the form: _____