COVID-19 Health Screening Form - Resident

Residents in an assisted living home must be monitored and assessed for COVID-19 daily. If you observe, or the resident answers YES to any of these questions, or has a temperature over 100.3°F, contact the medical provider for the resident and notify the Hope Health Line. This form must be completed weekly and saved in a secure location in the home.

Resident Name: _____ Week Of: _____

Questions		
	YES	**NO**
Was their temperature at or above 100.3° F?		
Did they have any symptoms? If yes, check the box next to each symptom(s) they have experienced in the last week: ☐ Cough ☐ Loss of appetite ☐ Significant fatigue ☐ Diarrhea ☐ Shortness of breath ☐ Difficulty breathing ☐ Muscle aches or pain ☐ Chills ☐ Repeated shaking with chills ☐ Headache ☐ Sore throat ☐ Runny nose ☐ Vomiting ☐ New loss of sense of smell or altered taste		
Have they had contact with someone with symptoms, who has tested positive for COVID-19, or who is being tested for COVID-19 due to symptoms?		
Have they returned from out-of-state travel in the last 5 days?		

Name of person completing this form: _____

Signature: _____

Date completed: _____