Note: Page 2 has instructions

SCREENING LOG DATE: _____

NOTE: Screening questions first, temperature *last*

TIME	NAME (first and last)	Destination	Exposure	Cough	Shortness of breath	Loss smell/ taste	Muscle Pain	Chills	Headache	Sore Throat	ANY SYMPTOMS in the last 48 hrs	Last Dose Acetaminophen (Tylenol) or Ibuprofen (Advil)	TEMP <100.0	ACCEPT	Initials
00:00	*I M Screener*		*No*	*No*	*No*	*No*	*No*	*No*	*No*	*No*	*irritated eyes (pollen)*	*5/12*	*98.2*	*Yes*	*IMS*
00:05	*Ben Teacher*		*No*	*No*	*No*	*No*	*No*	*No*	*Yes*	*No*	*headache*	*7 am*	*98.6*	*NO*	*IMS*

Screener Name (print):	Screener Name (print):	Screener Name (print):

SCREENING LOG	
*The first person being screened must be the Screener.	
*Every person entering the building must be screened.	
*Screening must be documented concurrently.	
*Screener should wear face covering (non-medical/surgical) to check temperature.	
*Ideally use infrared thermometer to increase distance.	
DATE:	Only one date per page; use new page for different date
TIME	Actual time of assessment - must be same time as documentation
NAME (first and last)	Full first name and last name
Exposure	Known exposure in the last 2 weeks, including co-habiting or within 6 feet of anyone who was ill; travel including to any nursing home, out of state, or any location that has been closed due to illness in the past 2 weeks; if YES, send home
Cough	Dry cough; if YES, send home
Shortness of breath	Shortness of breath while sitting or standing; observe for panting or wheezing after the walk in from the parking lot; if YES, send home
Loss smell/ taste	Unable to taste or smell normally; if YES, send home
Muscle Pain	Experiencing muscle pain or body aches; if YES, send home
Chills	Experiencing chills (coldness accompanied by shivering); if YES, send home
Headache	Experiencing headaches; if YES, send home
Sore Throat	Experiencing a sore throat; if YES, send home
ANY SYMPTOMS in the last 48 hrs	Assess any and all symptoms in last 48 hours - when in doubt, send home
Last Dose Acetaminophen (Tylenol) or Ibuprofen (Advil)	Must be at least 24 hours before this temperature check ; if less than 24 hours, send home
TEMP <100.0	Any temperature of 100.0 or more, send home;
ACCEPT	Enter Yes or No, based on assessment of all screening criteria; When in doubt, send home
Initials	Legible initials of the person documenting the screening
Screener Name (print)	Print full first and last name of the person documenting the screening
RECORD RETENTION	School Nurse will retain this document for at least one calendar year from date of assessment