NBCC Screening Form

Date: _____ Time: _____

Name: _____

Screened by: _____

Do you have any signs or symptoms of a respiratory infection, such as the following (these are some of the symptoms listed by the CDC)?

- Have you been treated for COVID-19
- Have you been in close contact with someone who has had COVID-19
- Fever or chills
- Sore throat
- Cough (new or changed)
- Muscle aches
- Fatigue or repeated shaking
- Decreased appetite
- Loss of smell or taste or neurological issues
- Shortness of breath or difficulty breathing
- Chills
- Headache
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

Yes _____ No _____

If yes to any of the above you cannot enter the building.

Signature _____