





Department of Health & Human Services

110 Fifth Street, Suite 500 Salem, New Jersey 08079 856-935-7510

COVID-19 SCREENING QUESTIONNAIRE

In the past 24 hours, have you experienced:

Fever:

Yes

No

Fatigue:

Yes

No

Cough:

Yes

No

Sneezing:

Yes

No

Aches and Pains:

Yes

No

Recent loss of taste or smell:

Yes

No

Runny or Stuffy Nose:

Yes

No

Sore throat:

Yes

No

Nausea, Vomiting:

Yes

No

Diarrhea:

Yes

No

Headaches:

Yes

No

Shortness of breath:

Yes

No

Other: \_\_\_\_\_

Have you recently been in close contact (within 6ft for ≥ 10 Minutes) with anyone who has exhibited any symptoms of COVID-19?

Yes

No

Have you recently been in contact with anyone who has tested positive for COVID-19?

Yes

No

I attest that the foregoing information is true and correct

Patient Name: \_\_\_\_\_

Signature of patient/guardian: \_\_\_\_\_

Date: \_\_\_\_\_

Clinic/Office Address: Salem County Health Department

All information on this form has been reviewed and the patient certifies that all information is true and correct as of the last 24 hours.

Signature/Title of Vaccine Administrator \_\_\_\_\_