First Coast Technical College
Your Future Comes First

Health Screening Entry Form

Student Name _____ **Date** _____

Screener Name _____ **Date** _____

Have you had any of the following since the last time you were here? (check any that apply):

- O Testing for COVID-19.
- O A fever of 100.4 or higher or a sense of having a fever.
- O A cough that you cannot connect to another health problem.
- O Shortness of breath that you cannot connect to another health problem.
- O A sore throat that you cannot connect to another health problem.
- O Diarrhea.
- O Muscle aches that you cannot connect to another health problem or activity, such as physical exercise.
- O Does anyone in your household have any of the above signs/symptoms right now?
- O Have you had close personal contact with anyone confirmed or suspected with COVID-19?