Loomis Communities - COVID-19 Screening **Resident Name** _____

At this point in time, do you have any of the following symptoms:

Please fill in the date	**___ /___ / 20**	**___ /___ / 20**	**___ /___ / 20**	**___ /___ / 20**	**___ /___ / 20**	**___ /___ / 20**	**___ /___ / 20**
fever above 100.0° F, feverish, chills?	_____ ° F yes / no	_____ ° F yes / no	_____ ° F yes / no	_____ ° F yes / no	_____ ° F yes / no	_____ ° F yes / no	_____ ° F yes / no
cough?	yes / no	yes / no	yes / no	yes / no	yes / no	yes / no	yes / no
shortness of breath?	yes / no	yes / no	yes / no	yes / no	yes / no	yes / no	yes / no
sore throat?	yes / no	yes / no	yes / no	yes / no	yes / no	yes / no	yes / no
new loss of taste?	yes / no	yes / no	yes / no	yes / no	yes / no	yes / no	yes / no
new loss of smell?	yes / no	yes / no	yes / no	yes / no	yes / no	yes / no	yes / no
new onset of headache?	yes / no	yes / no	yes / no	yes / no	yes / no	yes / no	yes / no
new onset of nausea?	yes / no	yes / no	yes / no	yes / no	yes / no	yes / no	yes / no
new onset of diarrhea?	yes / no	yes / no	yes / no	yes / no	yes / no	yes / no	yes / no
Please list the names of people you have come into contact with for each day. *(Contact is defined as: within six feet for at least 15 minutes)*							