COVID-19 Daily
Symptom Screening Tool

If symptoms are severe and life-threatening (i.e. tightening of the chest, inability to breathe, etc.), call 911.

Name of resident: _____ Date:_____

Resident Room: _____

Vaccinated? ___ Yes ___ No Boosted? ____Yes ____No

Have you had any of the following symptoms?

	Check all that apply – and when did it start?
Cough	
Trouble breathing, shortness of breath, or severe wheezing	
Fever, Chills or repeated shaking with chills	
Muscle/body aches	
Sore throat	
Diarrhea	
Loss of smell or taste, or a change in taste	
Headache	
Congestion / Runny Nose	
Nausea or vomiting	