COVID-19 SCREENING CHECK SHEET

To be completed Prior to Entering ZRCC

A separate Form for everyone must be completed

Visit Date: _____ Day: _____ Time: _____am / pm

Screening Questions:

1. I am fully vaccinated against COVID-19 (it has been 14 days or more since your final dose of either a two-dose or a one-dose vaccine series)?

	YES	NO
Vaccinated as per above		

You must answer "YES" to Question 1 in order to enter the OZCF facility or talk to Xerxes Madan.

2. Have you had any of the following symptoms in the last 24 hours?

	YES	NO
Severe difficulty breathing		
Severe chest pain		
Sore throat		
Feeling confused or unsure of where you are		
Losing consciousness		

Are you currently experiencing any of these symptoms?

	YES	NO
Fever and/or chills (temp of 37.8 deg. C or higher)		
Cough or barking cough (croup)		
Shortness of breath		
Decrease or loss of taste or smell		
Muscle aches/joint pain		
Extreme tiredness		

3. In the last 14 days have you:

	YES	NO
Been in contact with someone who was diagnosed with COVID-19?		
Been in close contact with someone who had COVID-10 symptoms?		
Travelled internationally or taken a cruise		

If you answer "YES" to any questions in 2 or 3, please DO NOT enter the OZCF facility.

PRINT NAME: _____ SIGNATURE:_____ Phone No._____
(a parent or guardian must sign on behalf of children 19 years and under)