Generic Screening Questionnaire for Home Visiting Staff
To be used before the home visit

1) Have you been completely vaccinated (more than 2 weeks from final dose of an FDA-authorized COVID-19 vaccine)?	☐ Yes ☐ No
IMPORTANT: DO NOT CONDUCT HOME VISIT IF ANSWER TO ANY QUESTION BELOW IS YES	
2) Do you CURRENTLY have ANY of the following NEW symptoms? • Fever (either felt or measured) or chills • Cough • Shortness of breath or difficulty breathing • Fatigue • Unexplained muscle or body aches • Unusual headache • Loss of taste or smell • Sore throat • Nasal congestion or runny nose • Nausea or vomiting • Diarrhea	☐ Yes ☐ No **If required, record screening temperature: ______________** **(Do not conduct home visit if temperature 100.4°F or greater)**
3) In the PAST 10 DAYS, have you had any of the following (regardless of your COVID-19 vaccination status): • **POSITIVE COVID-19 test?** • **NEW symptoms of COVID-19 (from above list)?**	☐ Yes ☐ No
4) Within the last 14 days, have you: • Had ***close contact**** with someone diagnosed with or tested for COVID-19 because of symptoms, or • Been told to quarantine by a health care provider or local health department because of ***close contact*** with someone with COVID-19?	☐ Yes** ☐ No **Individuals who answer “YES” to close contact but are fully vaccinated MAY be permitted to conduct home visit if approved by supervisor

*Close contact means being within six (6) feet for a total of 15 minutes or more over a 24-hour period (for example, three 5-minute exposures for a total of 15 minutes).

Name of Staff Completing Form ________________________________ Date:___________ Time: ___________
(Please print)

6/15/2021 (Revised)

GENERIC SCREENING QUESTIONNAIRE FOR HOME VISITING CLIENTS

IMPORTANT: DISCUSS WITH SUPERVISOR PRIOR TO HOME VISIT IF THE ANSWER TO ANY QUESTION BELOW IS YES	
1) Does any member of the household CURRENTLY have ANY of the following NEW symptoms? • Fever (either felt or measured) or chills • Cough • Shortness of breath or difficulty breathing • Fatigue • Unexplained muscle or body aches • Unusual headache • Loss of taste or smell • Sore throat • Nasal congestion or runny nose • Nausea or vomiting • Diarrhea	☐ Yes ☐ No
2) In the PAST 10 DAYS, has anyone in the household had any of the following: • **POSITIVE COVID-19 test?** • **NEW symptoms of COVID-19 (from above list)?** • **NEW symptoms of COVID-19 and a test that is not back yet?** • **NEW symptoms of COVID-19, even though you are fully vaccinated?**	☐ Yes ☐ No
3) Within the last 14 days, have you: • Had ***close contact**** with someone diagnosed with or tested for COVID-19 because of symptoms, or • Been told to quarantine by a health care provider or local health department because of ***close contact*** with someone with COVID-19?	☐ Yes ☐ No

*Close contact means being within six (6) feet for a total of 15 minutes or more over a 24-hour period (for example, three 5-minute exposures for a total of 15 minutes).

Name of Staff Completing Form ________________________________ Date:____________ Time: ____________
(Please print)