

**JFK DENTAL COVID-19 HEALTH SCREENING QUESTIONNAIRE**

1. Have you been exposed to anyone who tested positive for COVID-19 (Coronavirus)?

**Yes**

**No**

2. Have you been out of the Sate of Arkansas in the last two weeks?

**Yes**

**NO**

3. Do you have a fever or have had a fever in the last week?

**Yes**

**NO**

4. Have you had any cold/flu symptoms in the last week?

**Yes**

**NO**

5. Have you had a cough in the last week?

**Yes**

**NO**

Today's Temperature: \_\_\_\_\_

Notes:

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_