Philadelphia Department of Public Health
COVID-19 Screening Tool

Date: ____________________________

Name: ____________________________________________

1. TEMPERATURE: ______ °F  □ Temperature taken on-site  □ Temperature taken at home

   IF temperature 100.4°F or higher → do not allow into the facility

2. SYMPTOMS
   Do you have any of the following?

   □ Cough       □ Shortness of breath

   OR

   □ Fever       □ Sore throat
   □ Chills       □ Muscle pain
   □ Headache     □ New loss of taste or smell

   If YES to either → do not allow into the facility

   OR

   If YES to 2 or more → do not allow into the facility

3. VISUAL INSPECTION
   Does the individual have flushed cheeks, rapid breathing or difficulty breathing (without recent physical activity), fatigue, or extreme fussiness (in a child), or cough?

   □ Yes  □ No  Comments:

   If YES → do not allow into the facility

4. EXPOSURE
   Have you been exposed to anyone with a confirmed case of COVID-19 in the past 14 days?

   □ Yes  □ No  Comments:

   If YES → do not allow into the facility