Mifflin County Academy of Science & Technology
COVID-19 Screening Checklist
General Visitors

Name: ____ **Date:** ____________________

Temperature	❒ Below 100 (Using the infrared touchless ❒ Above 100 thermometer.)
Are you taking a fever reducing medication?	**Yes** **No** ❒ ❒
<u>Group A:</u> **Are you experiencing 1 or more of these symptoms?**	**Yes** **No** ❒ ❒ Cough ❒ ❒ Short of Breath ❒ ❒ Difficulty Breathing ❒ ❒ New loss smell ❒ ❒ New taster disorder
<u>Group B:</u> **Are you experiencing 2 or more of these symptoms?**	**Yes** **No** ❒ ❒ Fever ❒ ❒ Chills ❒ ❒ Repeated shaking with chills ❒ ❒ Muscle pain ❒ ❒ Headache ❒ ❒ Sore Throat ❒ ❒ Nausea or vomiting ❒ ❒ Diarrhea ❒ ❒ Fatigue ❒ ❒ Congestion or runny nose
Have you been tested + for COVID-19? **Have you been exposed to anyone who has been tested + for COVID-19 within the last 14 days?**	**Yes** **No** ❒ ❒ Date ____________________ ❒ ❒ Date ____________________
Have you traveled outside of PA or to a region within PA that is considered a high-risk area for COVID?	**Yes** **No** ❒ ❒ Date of Return ______________
What is the purpose of your visit?	
Please stay home if you fall into one of the three categories below: • **Have one or more symptoms in Group A** • **Have two or more symptoms in Group B** • **Fever and or taking fever reducing medication.**	

To the best of my knowledge, I have answered the above screening questions truthfully and honestly. I understand to participate in classroom/lab/simulation/clinical activities I must comply with the policies and procedures put forth during the COVID-19 pandemic.

Visitor Signature: ______________________________ Date: ____________________

Faculty/Staff Initials: ___________________________ Date: ____________________