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

Name: _____ Date: _____

Group A: **Are you experiencing 1 or more of these symptoms?**	**Yes** **No** ❒ ❒ Cough ❒ ❒ Short of Breath ❒ ❒ Difficulty Breathing ❒ ❒ New loss smell ❒ ❒ New taster disorder
Group B: **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 exposed to anyone who has been tested + for COVID-19 within the last 14 days?	**Yes** **No** ❒ ❒ Date _____
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**	

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: _____

Revised 9/3/2021