COVID19 screening form.

Full Name *

First Name Last Name

Email

example@example.com

Phone Number *

Area Code Phone Number

Do you have any of the following symptoms?: *

- ☐ New and persistent cough
- ☐ Shortness of breath or any difficulty breathing
- ☐ Fever
- ☐ No symptoms present

Have you been in contact with anyone in the last 14 days who is experiencing these symptoms? *

- ○ Yes
- ○ No

Have you been in contact with anyone who has since tested positive for Covid-19? *

- ○ Yes
- ○ No
- ○

Have you returned from travel (including Canada) in the last 14 days?

SWIS Program Name and Date: *

Submit