COVID-19 Weekly Screening Form

DEMOGRAPHIC, EXPOSURE, CLINICAL, AND LABORATORY INFORMATION

Name:	Birthdate:	Sex: M / F
Reservation District (circle one): Fort Hall / Gibson / Ross Fork / Lincoln Creek / Bannock Creek		
Phone Number Where You Can Be Reached **TODAY**:		
Have you had an exposure with a direct contact? Yes / No / Unknown	Exposure Date:	
Type of contact: Community / Household / Work / Unknown / Other:		

Have you had any of the following symptoms in the past 7 days:

Fever or feverishness: Yes / No
Chills: Yes / No
Cough: Yes / No
Sore throat: Yes / No
Runny Nose: Yes / No
Nasal congestion: Yes / No
Headache: Yes / No
Loss or taste or smell: Yes / No
Vomiting: Yes / No
Diarrhea: Yes / No
Abdominal pain: Yes / No
Fatigue or feeling run down: Yes / No
Muscle pain or body aches: Yes / No
Trouble breathing or shortness of breath: Yes / No
Wheezing: Yes / No
Chest tightness or chest pain: Yes / No

Date when symptoms started:

Have you sought medical care (in person or virtual/telephone) or been seen at the hospital for any of the above symptoms during the last 2 weeks? Yes / No
If yes, where did you receive care?
If yes, what medications (including over-the-counter) did you take/were you given?

HOUSEHOLD PREVENTION PRACTICES

In the past 7 days, has your household been cleaning and disinfecting high-touch surfaces in the household daily (e.g., tables, hard-backed chairs, doorknobs, light switches, phones, tablets, touch screens, remote controls, keyboards, handles, desks, toilets, sinks)? Yes / No
If yes, what frequency? How many times?

In the past 7 days, have you shared a room to sleep? Yes / No
If yes, with how many people:
If yes, how many times?
If yes, did you sleep in the same bed?

In the past 7 days, have you shared a bathroom? Yes / No
If yes, with how many people?

In the past 7 days, have you and household members been washing/sanitizing hands frequently? Yes / No
If yes, specify method(s): Running Water / Hauled Water / Sanitizer / Other (specify):

Are you able to isolate a sick person in your household? Yes / No
If yes, specify how:

INDIVIDUAL QUESTIONS ABOUT HOUSEHOLD PRACTICES

In the past 7 days, have your household members been wearing masks when they go out of the house, including to visit other homes? Yes / No

In the past 7 days, have you been sharing common living spaces (for eating, relaxing)? Yes / No
If yes, with up to how many people:

Is there currently a COVID-19 positive person in your household? Yes / No
In the past 7 days, have you been wearing masks in your house? Yes / No
If yes, how often?
In the past 7 days, have you shared cups, hugged, or had other close contact with the positive person? Yes / No

COVID-19 Test Information

Lab Test Date:	Test Kit Lot #:
Test Result: Positive / Negative	