BEHAVIORAL & COUNSELING
• SERVICES •

# TRAVEL SCREENING INFORMATION

BCS is following the Centers for Disease Control and Prevention travel screening guidelines. Please complete the following questions:

**HAVE YOU OR ANYONE YOU ARE IN CLOSE CONTACT WITH:**

| | | |
|---|---|---|
| Been in contact with anyone that has been diagnosed or is being monitored by the CDC for COVID-19 in the last 30 days? | ☐ **Yes** | ☐ **No** |
| Traveled out of the country in the last 30 days? | ☐ **Yes** | ☐ **No** |
| Traveled on a cruise ship in the last 30 days? | ☐ **Yes** | ☐ **No** |
| If yes, what country did you / they visit? _____ | | |

**Are you / they currently experiencing any of the following symptoms?**

| | | |
|---|---|---|
| Fever (greater than 100.4°F / 38.0°C) | ☐ **Yes** | ☐ **No** |
| Severe Headache | ☐ **Yes** | ☐ **No** |
| Muscle Pain / Weakness | ☐ **Yes** | ☐ **No** |
| Diarrhea / Vomiting / Abdominal Pain | ☐ **Yes** | ☐ **No** |
| Respiratory Symptoms / Shortness of Breath | ☐ **Yes** | ☐ **No** |
| Rash / Skin Irritation | ☐ **Yes** | ☐ **No** |
| Unexplained Bleeding or Bruising | ☐ **Yes** | ☐ **No** |

**Printed Name** **Signature** **Date** **Time**

Clinical Staff Notification Required? _____Yes _____No

☐ Language/Translation Line Utilized