FOR OFFICIAL USE ONLY

# MISAWA AB COVID-19 IN-PROCESSING SCREENER

***PLEASE write slowly & legibly. If your information cannot be read, it may prolong your ROM time.***

| Today's Date | |
|---|---|
| Sponsor Full Name | |
| DOB | |
| DOD ID Number | |
| SSN (if no DOD ID #) | |
| Personal Email Address | |
| Phone Number | |

Dependents:

| Full Name | |
|---|---|
| DOD ID Number | |
| SSN (if no DOD ID #) | |

| Full Name | |
|---|---|
| DOD ID Number | |
| SSN (if no DOD ID #) | |

| Full Name | |
|---|---|
| DOD ID Number | |
| SSN (if no DOD ID #) | |

| Full Name | |
|---|---|
| DOD ID Number | |
| SSN (if no DOD ID #) | |

1. Have you recently experienced any of the following symptoms?

| | | | |
|---|---|---|---|
| | None | | |
| | Fever | | Loss of taste or smell |
| | Cough | | Sore throat |
| | Shortness of Breath | | Chills |

2. Have you been in close contact with anyone who is confirmed case of COVID-19?

| | | | |
|---|---|---|---|
| | Yes | | No |

3. Have you tested POSITIVE for COVID-19 in the last 90 Days?

| | | | |
|---|---|---|---|
| | Yes | | No |

4. If you answered YES to question THREE where did you get your confirmed POSITIVE?

5. Do you think in the past 90 days that you contracted the COVID-19 virus based on prior symptoms?

| | | | |
|---|---|---|---|
| | Yes | | No |

Dependents:

| Full Name | |
|---|---|
| DOD ID Number | |
| SSN (if no DOD ID #) | |

| Full Name | |
|---|---|
| DOD ID Number | |
| SSN (if no DOD ID #) | |

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