Pre-Screening Tool
For Emittance To Leon County Schools Fingerprint Office

Name: _____Signature:_____

Contact Number: _____

Email Address: _____

Date of Screening:	**Time of Screening:**	**Decision for Entry**
		If showing or presenting signs or symptoms of respiratory infection, including fever, cough, shortness of breath, **or a combination** of the listed symptoms: **STOP, Entry NOT Allowed!**
Do you have now or in the last 14 days had the following: Shortness of Breath: ☐ Yes ☐ No Cough: ☐ Yes ☐ No *OR at least two of these symptoms:* Sore Throat: ☐ Yes ☐ No Chills: ☐ Yes ☐ No Fever: ☐ Yes ☐ No Headache: ☐ Yes ☐ No Muscle Pain: ☐ Yes ☐ No Diarrhea: ☐ Yes ☐ No Repeated Shaking with chills: ☐ Yes ☐ No New Loss of Taste or Smell: ☐ Yes ☐ No		
Have you been in close contact with person(s) infected with COVID-19 ☐ Yes ☐ No		If answer is YES: **STOP, Entry NOT Allowed!**
Have you traveled through an airport or on a cruise ship within the last 14 days? **☐ Yes ☐ No**		If answer is YES: **STOP, Entry NOT Allowed!**