GASCO
GEORGIA SOCIETY OF CLINICAL ONCOLOGY

GASCO 2020 FALL ADMINISTRATION AND BUSINESS OF ONCOLOGY MEETING

COVID-19 ATTENDEE SCREENING QUESTIONNAIRE

Attendee Name: _____ Date: _____

☐ Friday and Saturday Attendee ☐ Friday Attendee Only ☐ Saturday Attendee Only

SCREENING QUESTIONS:

Do you have fever, or have you felt feverish recently?	☐ YES	☐ NO
Do you have a cough?	☐ YES	☐ NO
Are you having shortness of breath or any difficulty breathing?	☐ YES	☐ NO
Do you have chills or repeated shaking with chills?	☐ YES	☐ NO
Do you have any muscle pain?	☐ YES	☐ NO
Do you have any recent onset of headache or sore throat?	☐ YES	☐ NO
Do you have any other flu-like symptoms?	☐ YES	☐ NO
Do you have any recent loss of taste or smell?	☐ YES	☐ NO
Have you experienced any recent GI upset or diarrhea?	☐ YES	☐ NO
Are you in contact with anyone who has been confirmed to be COVID-19 positive?	☐ YES	☐ NO
Have you traveled in the past 14 days to any domestic regions affected by COVID-19?	☐ YES	☐ NO
Have you traveled outside of the continental United States in the past 30 days to a country known to be affected by COVID-19?	☐ YES	☐ NO
Have you been tested for COVID-19? If yes, when? _____ Test Result: ☐ Positive ☐ Negative	☐ YES	☐ NO
Are you over the age of 65?	☐ YES	☐ NO

Do you have any of the following diseases putting you at higher risk if Infected with COVID-19?:

☐ Heart Disease ☐ Lung Disease ☐ Kidney Disease ☐ Diabetes ☐ Autoimmune Disorders

Temperature read - Friday: _____ ☐ Cleared to Attend ☐ Attendance Denied

Temperature read - Saturday: _____ ☐ Cleared to Attend ☐ Attendance Denied

Screening Check Performed by: _____ _____

Friday Saturday