Covid-19 Symptom Screening for Livescan

Please fill out your name and initial the appropriate response the morning of your appointment. Bring this completed form along with your Livescan form to your appointment.

Name: _____ Date: _____

Position applying for:_____

Have you experienced any new or unexplained symptoms within the last 24 hours, such as: • Chills or Fever of 100.4 or above • Cough • Shortness of breath or difficulty breathing • Fatigue • Muscle or body aches • Headache • New loss of taste or smell • Sore throat • Congestion or runny nose • Nausea or vomiting • Diarrhea	Yes ☐	No ☐
Have you tested positive for COVID-19 in the past 10 days?	Yes ☐	No ☐
Have you been identified as a close-contact of someone who has tested positive for COVID-19 in the past 10 days?	Yes ☐	No ☐
Are you currently awaiting results from a COVID-19 test from a close contact exposure?	Yes ☐	No ☐

If you answer **Yes** to any of these questions, please contact the Fingerprinting Unit before coming in for your appointment for further instructions 650-599-1520.