



COVID-19 Workplace Health Screening

Name: _____ Time In: _____

Building Location(s): _____ Date: _____

1. In the last 14 days, have you developed any of the following symptoms that are new/different/worse from baseline of any chronic illness:

Subjective fever (felt feverish):	<input type="checkbox"/> Yes	<input type="checkbox"/> No
New or worsening cough:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Shortness of breath or difficulty breathing:	<input type="checkbox"/> Yes	<input type="checkbox"/> No

2. In the last 14 days, have you developed any of the following symptoms that are new/different/worse from baseline of any chronic illness:

Chills:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Headache:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sore throat:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Loss of smell or taste:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Muscle aches:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Vomiting:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diarrhea:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Current Temperature:		

DISCLAIMER: This screening tool is subject to change based on the latest information on COVID-19

If you answer **YES** to any of the symptoms listed in section 1, **OR YES** to two or more of the symptoms listed in section 2, **OR** your temperature is **100.4°F or higher**, please do not go into work. Self-isolate at home and contact your primary care physician's office for direction.

- You should isolate at home until you are fever free for at least 24 hours, your symptoms are improving, and it has been at least 10 days since symptoms first appeared or per guidance of your local health department or healthcare provider.
 - If diagnosed as a probable COVID-19 or test positive, call your local health department and make them aware of your diagnosis or testing status.

In the past 14 days, have you:

Had close contact with an individual diagnosed with COVID-19?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you been told by the health department or your healthcare provider to self-isolate or self-quarantine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you traveled internationally or taken a cruise?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If you answer **YES** to either of these questions, please do not go into work. Self-quarantine at home for 14 days. Contact your primary care physician's office if you have symptoms or have had close contact with an individual for evaluation. If you are given a probable diagnosis or test positive call your local health department to ensure they are aware.

Signature: _____ Date: _____