COVID-19 Workplace Health Screening

Company Name: _____

Employee: _____ Date: _____

Time In: _____

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:

New or worsening cough:	☐ Yes	☐ No
Shortness of breath or difficulty breathing:	☐ Yes	☐ No
New loss of or change in taste or smell	☐ Yes	☐ 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:

Fever:	☐ Yes	☐ No
Chills:	☐ Yes	☐ No
Uncontrollable shivering or sweating:	☐ Yes	☐ No
Headache:	☐ Yes	☐ No
Sore throat:	☐ Yes	☐ No
Runny nose or congestion:	☐ Yes	☐ No
Muscle aches:	☐ Yes	☐ No
Fatigue:	☐ Yes	☐ No
Nausea or vomiting:	☐ Yes	☐ No
Diarrhea:	☐ Yes	☐ No

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** if 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. If you are already at work, self-isolate to the best of your abilities and contact your supervisor.

- You should isolate at home for a minimum of 10 days since symptoms first appeared.
- You must also have 24 hours without a fever (without using a fever reducing medication) and improvement in symptoms.

In the past 14 days, have you:

Had close contact with an individual diagnosed with COVID-19?	☐ Yes	☐ No
Traveled Internationally? (subject to change per State guidance)	☐ Yes	☐ No

If you answer **YES** to either of these questions, please do not go into work. Self-quarantine at home for 10 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 supervisor to ensure they are aware.