Coronavirus Disease (COVID-19) Health Screening

Company Name: _____

Employee Name: _____

Date: _____ Time In: _____

In the past 24 hours, have you experienced:

Subjective fever (felt feverish): Yes □ No □
New or worsening cough: Yes □ No □
Shortness of breath: Yes □ No □
Sore throat: Yes □ No □
Diarrhea (unless due to known cause): Yes □ No □
Current temperature:

If you answer **"yes"** to any of the symptoms listed above, or your temperature is **100.4°F or higher**, please do not go to into work. Self-isolate at home and contact your primary care physician's office or nearest urgent care facility for further instruction.

• You should isolate at home for a minimum of 7 days since symptoms first appear.

• You must also have 3 days without fevers and improvement in respiratory symptoms.

In the past 14 days, have you:

Had close contact with an individual diagnosed with COVD-19? Yes □ No □

Traveled internationally or domestically? Yes □ No □

If you answer **"yes"** to either of these questions, please do not go into work (unless exempt). Self-quarantine at home for 14 days.