

Coronavirus Disease (COVID-19 Workplace 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

Vomiting/Diarrhea: 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 into work. Self- isolate at home and contact your primary care physician’s office for direction.

- You should isolate at home for minimum of 7 days since symptoms first appear.
- You must also have 3 days without fevers and improvement in respiratory symptoms

Have you had close contact in the last 14 days with an individual diagnosed with COVID-19? Yes No

Have you engaged in any activity or travel within the last 14 days which fails to comply with the *Stay Home, Stay Safe* Executive Order? Yes No

Have you been directed or told by the local health department or your healthcare provider to self-isolate or self-quarantine? Yes No

If you answer “yes” to either of these questions, please do not go into work. Self-quarantine at home for 14 days.