

# COVID-19 Employee Self-Screening Form

Monitor your health each day prior to reporting to work. If you begin to show symptoms of COVID-19, do not report to work and contact your supervisor.

**Section 1:** In the last 24 hours, have you developed any of the following symptoms that are new/different/worse from baseline of any chronic illness:

Cough:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Shortness of breath:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Difficulty breathing:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
New loss of smell:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
New loss of taste:	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Section 2:** In the last 24 hours, have you developed any of the following symptoms that are new/different/worse from baseline of any chronic illness:

Subjective fever (felt feverish) or measured temperature of 100.4°F or higher:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chills or rigors (severe chills with shivering):	<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
Runny nose or congestion:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Muscle aches:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fatigue:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Nausea:	<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

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**, please do not go into work. Self-isolate at home and contact your healthcare provider for direction and possible testing for COVID-19.

**In the past 14 days, have you:**

Had close contact with an individual who has tested positive for COVID-19?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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If you answer **YES** to the above question, please do not go into work. Self-quarantine at home for 10 days unless diagnosed with COVID-19 in the past 3 months or fully vaccinated against COVID-19. Contact your healthcare provider if you have symptoms.

