COVID-19 Employee Self-Screening Form

This information will be maintained separately from Employment Records

Employee Name: _____

Date: _____/_____/_____

In the past 24 hours, have you experienced any of the following:

Symptom	Yes	No
Cough		
Shortness of Breath		
Fever (100.4°F or above or otherwise high for you)		
Chills		
Muscle Pain		
Sore Throat		
New Loss of Taste or Smell		
Congestion or runny nose		
Nausea or vomiting		
Diarrhea		

**If symptoms such as shortness of breath are due to a known, non-worsening chronic condition, mark "No".*

If you indicated "Yes" to any of the symptoms listed above, do not report to the workplace. Immediately contact NAME at ###-###-#### to report your symptoms and absence from work. You must self-isolate at home for a minimum of 7 days from the time symptoms began *and* contact your healthcare provider for further direction. You may return to work once you have achieved 3 days fever-free and symptom free (without the use of medicine). If symptoms develop while at work, you must, and agree to, report such to your manager and leave the workplace immediately.

Within the past 48 hours, have you had close contact with an individual who tested positive for, or was diagnosed with COVID-19?

☐ Yes ☐ No

If "Yes", contact NAME at ###-###-#### before reporting to the workplace to further discuss.

_____

Employee Signature

*This questionnaire must be completed and provided prior to each shift

CDC Symptoms and Self-Checker: https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html

Updated 5/28/2020

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