EMPLYOYEE HEALTH SCREENING QUESTIONAIRE

NAME: _____ DATE: _____

☐ **YES** ☐ **NO** **ARE YOU EXPERIENCING A COUGH OR DIFFICULTY BREATHING?**
EMPLOYER: IF YES, REFER TO EMPLOYEE HEALTH GUIDELINES

☐ **YES** ☐ **NO** **HAVE YOU HAD A FEVER OF AT LEAST 100° IN THE LAST 48 HOURS?**

☐ **YES** ☐ **NO** **DO YOU HAVE CHILLS?**

☐ **YES** ☐ **NO** **REPEATED SHAKING WITH CHILLS?**

☐ **YES** ☐ **NO** **MUSCLE PAIN?**

☐ **YES** ☐ **NO** **HEADACHE?**

☐ **YES** ☐ **NO** **SORE THROAT?**

☐ **YES** ☐ **NO** **NEW LOSS OF TASTE OR SMELL?**

☐ **YES** ☐ **NO** **VOMITING OR DIARRHEA?**

EMPLOYER: IF YES TO 2 OR MORE OF THE ABOVE QUESTIONS, REFER TO EMPLOYEE HEALTH GUIDELINES

☐ **YES** ☐ **NO** **HAD CLOSE CONTACT WITH A CONFIRMED CASE OF COVID-19?**

EMPLOYER: CONTACTS SHOULD STAY AT HOME FOR 14 DAYS FROM LAST CONTACT AND MONITOR FOR SYMPTOMS

TEMPERATURE: _____

EMPLOYEE:

- **DO NOT WORK IF YOU ARE FEELING SICK**
- **DO NOT WORK IF YOU HAVE HAD DIARRHEA OR VOMITING IN THE LAST 48 HOURS**
- **DO NOT WORK IF YOU HAVE SYMPTOMS OF A RESPIRATORY INFECTION SUCH AS SHORTNESS OF BREATH, COUGH, SORE THROAT, ETC.**
- **DO NOT WORK IF YOU HAD CONTACT WITH SOMEONE WITH KNOWN OR SUSPECTED CORONAVIRUS IN THE LAST 14 DAYS**