EMPLOYEE COVID-19 SCREENING PROTOCOLS QUESTIONNAIRE

(REQUIRED UPON ARRIVING AT AND LEAVING WORK)

Name: ____________________________________ **Date:** ________________________

Arriving: _____ **Leaving:** _____

Do you have any of the following?

Fever or chills: ____Yes ___ No
Cough: ____Yes ___ No
Fatigue: ____Yes ___ No
Headache: ____Yes ___ No
Sore throat: ____Yes ___ No
Diarrhea: ____Yes ___ No
Nausea or vomiting: ____Yes ___ No
Congestion or runny nose: ____Yes ___ No
Muscle or body aches: ____Yes ___ No
New loss of taste or smell: ____Yes ___ No
Shortness of breath or difficulty breathing: ____Yes ___ No

Have you had any close contact in the last 14 days with anyone with a diagnosis of COVID-19?

____Yes ___ No

If you answered "yes" to any of the questions above, you cannot be admitted to the building and are directed to return home and immediately contact your Department Head.

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