Infectious Disease COVID-19 Symptoms Self Reporting Form

Name:	**Employee: Yes:_____ No:_____** **Visitor: Yes:_____ No:_____**
Today's Date:	**Contact Phone: ( ) _____** **E-mail:_____**

Signs & Symptoms

Please review the symptom columns below and check off any of the symptoms you may have experienced within the last 2 weeks.

Temperature above 100.4 degrees	Body Aches	Headache	Chills	Sore Throat	Difficulty breathing or Shortness of Breath	Cough	Loss of taste or smell	Traveled outside the country within last 2-4 weeks?

Have you been tested or diagnosed with the Coronavirus (COVID-19)? Yes_____ No_____

If yes, have you been cleared by a doctor and tested negative? Yes_____ No_____

I have signs of a fever or a measured temperature above 100.4 degrees, a cough, or trouble breathing within the past 48 hours? Yes_____ No_____

Within the last 14 days, I have had "close contact" with an individual diagnosed with COVID-19. "Close contact" means living in the same household as a person who has tested positive for COVID-19, caring for a person who has tested positive for COVID-19, being within 6 feet of a person who has tested positive for COVID-19 for about 15 minutes, or coming in direct contact with secretions (e.g., sharing utensils, being coughed on) from a person who has tested positive for COVID-19, while that person was symptomatic? Yes_____ No_____

I've been asked to self-isolate or quarantine by a doctor or a local public health official? Yes_____ No_____

Thank you for completing this form.

Signature:	Today's Date: