

COVID-19 SCREENING QUESTIONNAIRE: NAME _____

1	<p>Are you currently experiencing, or have you experienced in the past 14 days, any of the following symptoms? <i>(Please take your temperature before you answer this question.)</i></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> Fever (100.4° F/37.8° C or greater as measured by an oral thermometer)</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> Cough</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> Shortness of breath or difficulty breathing</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> Sore throat</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> New loss of taste or smell</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> Chills</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> Head or muscle aches</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> Nausea, diarrhea, vomiting</p>
2	<p>In the past 14 days, have you been in close proximity to anyone who was experiencing any of the above symptoms or has experienced any of the above symptoms since your contact?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
3	<p>In the past 14 days, have you been in close proximity to anyone who has tested positive for COVID-19?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
4	<p>Have you been tested for COVID-19 and are waiting to receive test results?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
5	<p>Have you have tested positive for COVID-19, or are you presumptively positive for COVID-19 based on your health care provider's assessment or your symptoms?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p><i>NOTE: If you have tested positive for COVID-19 or have been presumptively positive for COVID-19 based on your health care provider's assessment or your symptoms, please contact your manager or human resources representative when: (1) you have had no fever for at least 72 hours (3 full days), without the use of fever-reducing medications; (2) your other symptoms have improved; and at least 7 days have elapsed since your symptoms first appeared.</i></p>
6	<p>In the past 14 days, have you been on a commercial flight or traveled outside of the United States?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
7	<p>In the past 14 days, have you been in close proximity to anyone who has been on a commercial flight or traveled outside of the United States?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>

Certification

I hereby certify that the responses provided above are true and accurate to the best of my knowledge.

Signature: _____

Date: _____