CORONAVIRUS DISEASE (COVID-19)

EMPLOYEE HEALTH SCREENING

To be completed before entering the workplace.

version 102320

County Department/Office: _____

Employee Name: _____ Date/Time: _____

In the past 24 hours, have you experienced any of the following symptoms?		
New or Worsening Cough	☐ YES	☐ NO
Shortness of Breath	☐ YES	☐ NO
Or at least two of the following:		
Fever (100.4 or above)	☐ YES	☐ NO
_____Current Temperature		
Chills/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/Diarrhea	☐ YES	☐ NO

If you answer **"yes"** to any of the above symptoms or your temperature is 100.4 or higher, you need to notify your Department Head/Elected Official and may not enter the workplace. Self-isolate at home and contact your primary care physician's office for direction. You will not be permitted into work until:

- Ten (10) days have passed since symptoms first appeared and at least 14 days since you were swabbed for the test that yielded the positive result; or
- You receive a negative COVID-19 test and are retested if required by the County.

In the past 14 days, have you:

• Had close contact (within approximately six (6) feet for an accumulated time of 15 minutes within 24 hours) with an individual diagnosed with COVID-19?	☐ YES	☐ NO
• Engaged in international travel or taken a cruise?	☐ YES	☐ NO
• Been told by the local health department or your healthcare provider to self-isolate or self-quarantine?	☐ YES	☐ NO

If you answered **"yes"** to any of the above questions, contact your Department Head/Elected Official and the Administrator Controller's Office and do not go into the workplace. Self-quarantine at home for fourteen (14) days or as prescribe by your healthcare provider.

Employee Signature_____; I truthfully attest that I have answered the questions above to the best of my ability.

Please return this completed screening to your Department Head/Elected Official or their designee.