

## COVID-19 SCREENING QUESTIONNAIRE

The safety of our employees/families is our overriding priority. In order to prevent the spread of the coronavirus and reduce the potential risk of exposure to our workforce, everyone must complete and submit this questionnaire prior to entering the worksite.

Please respond to each of the following questions truthfully and to the best of your ability.

1. Are you currently experiencing, or have you experienced in the past 14 days, any of the following symptoms that cannot be attributed to another health condition such as allergies or asthma. ***(Please take your temperature before you answer this question.)***

Yes\_\_ No\_\_ Fever (100.4 or greater as measured by an oral thermometer)

Yes\_\_ No\_\_ Cough

Yes\_\_ No\_\_ Shortness of breath or difficulty breathing

Yes\_\_ No\_\_ Sore throat

Yes\_\_ No\_\_ New loss of taste or smell

Yes\_\_ No\_\_ Chills

Yes\_\_ No\_\_ Muscle or body aches

Yes\_\_ No\_\_ Nausea, diarrhea, vomiting

Yes\_\_ No\_\_ Congestion or runny nose

Yes\_\_ No\_\_ Headache

2. Have you been in close contact with anyone with confirmed COVID-19?

Yes\_\_ No\_\_

3. Have you had a positive COVID-19 test for active virus in the past 10 days?

Yes\_\_ No\_\_

4. Within the past 14 days, has a public health or medical professional told you to self-monitor, self-isolate, or self-quarantine because of concerns about COVID-19 infection?

Yes\_\_ No\_\_

**IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, YOU CAN NOT GO TO SCHOOL.**

### Certification

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

Print Name (s): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_