Wellness Services Health Screening

Employee Name: _____ Time: _____

Employee Temperature: _____ Date: _____

In the past 24 hours, have you experienced:		
Fever	YES	NO
Cough (excluding chronic cough due to a known medical reason other than COVID-19)	YES	NO
Shortness of breath or difficulty breathing	YES	NO
Loss of taste or smell	YES	NO
If you answer "YES" to any of the symptoms listed above, or if your temperature is 100.4F or higher, please do not enter the workspace. Seek COVID-19 testing and isolate at home until test results are available.		

In the past 24 hours, have you experienced:		
Chills	YES	NO
Muscle aches	YES	NO
Headache	YES	NO
Sore throat	YES	NO
Fatigue (not otherwise explained by another known cause)	YES	NO
Diarrhea (excluding diarrhea due to a known medical reason other than COVID-19)	YES	NO
Nausea or vomiting	YES	NO
Congestion or runny nose	YES	NO
If you answer "YES" to any TWO of the symptoms listed above, please do not enter the workspace. Seek COVID-19 testing and isolate at home until test results are available.		

In the past 14 days, have you:		
Been in close contact with anyone diagnosed with COVID-19 (closer than 6 feet for more than 15 minutes, with or without masks)	YES	NO
If you answer "YES", please do not enter the workspace. Seek COVID-19 testing and isolate at home until test results are available.		