Employee COVID-19 Screening Form

Name: _____ Date: _____

Today or within the last 24 hours, have you experienced:

One of these symptoms

□ New or worsening cough
□ Shortness of breath / trouble breathing

OR at least TWO of these symptoms

□ Fever □ Headache □ Chills □ Vomiting □ New or worsening diarrhea

□ Sore Throat □ Stuffy Nose □ Fatigue □ New loss of taste or smell

□ Muscle pain/Body aches

□ **I do not have any of the symptoms described in this screening tool.**

Are you awaiting results from a COVID-19 test? □ Yes □ No

(If yes, please discuss circumstances with your Clinic Director)

I attest to the following:

□ I will not come to work if I have any symptoms described in this screening tool.

□ If I develop any symptoms of described on this screening tool while I am at work, I will immediately advise my supervisor and leave work.

□ If I develop any symptoms described in this screening tool, I will not return to work until I have been cleared to do so.

Signature: _____

*Clinic Director Signature: _____

*required if employee is awaiting test results or reports a symptom listed above that is attributable to something other than COVID-19.

□ Employee allowed to work □ Employee sent home

10/2020