Sample COVID-19 Screening Form for Employers

Name of Employee: Date:

1. Have you traveled outside of Country in the last 14 days (circle answer)? **YES** or **NO**
2. Has someone you are in close contact with tested positive for COVID-19

in the last 14 days? **YES** or **NO**

1. Are you in close contact with a person who is sick with new respiratory

symptoms or who recently traveled outside of the country? **YES** or **NO**

1. Do you have a fever? (temperature ≥ 37.8 °C) **YES** or **NO**

Tº (Screener will have employee take temperature)

1. Do you have any of these symptoms\* **YES** or **NO**
   * Chills
   * New or worsening cough (dry or productive)
   * Barking cough (croup)
   * Shortness of breath/difficulty breathing
   * Sore throat
   * Difficulty swallowing
   * Loss of taste or smell
   * Pink eye (conjunctivitis)

If you have answered:

* Headache that is unusual or long-lasting
* Runny or stuffy nose (not related to seasonal allergies or other known causes or conditions)
* Nausea/vomiting/diarrhea/abdominal pain
* Muscle aches
* Unexplained fatigue/malaise
* Falling more than usual
* Other
  + **NO** to **all** questions – **PASS**. You may enter the building and proceed as scheduled.
  + **YES** to any questions from #1 to #4 – **FAIL**. Put on a surgical mask, go home immediately and self-isolate. You may work from home if appropriate.
  + **YES** to **#5 only** – **FAIL**. Go to question #6.

1. Are these symptoms typical for you (i.e. history of allergies, migraines, other known medical conditions that usually causes these symptoms)?
   * **YES** – Please self-isolate. Contact your doctor for a note confirming that symptoms are typical before returning to work.
   * **NO** – Go home immediately and self-isolate. You may work from home if appropriate.

**Screener Signature: Employee Signature:**