|  |  |
| --- | --- |
| **Date:** |  |
| **Last Name:** |  |
| **First Name:** |  |
| **Actual Temp Check:** |  |
|  |  |
| **Y** | **N** | Symptoms of COVID-19 Within the past 14 Days |
|  |  | **Feeling feverish or a measured temperature greater than or equal to 100\* F** |
|  |  | **Cough** |
|  |  | **Shortness of breath or difficulty breathing** |
|  |  | **Chills** |
|  |  | **Repeated shaking with chills** |
|  |  | **Muscle pain** |
|  |  | **Headache** |
|  |  | **Sore Throat** |
|  |  | **Loss of taste or smell** |
|  |  | **Diarrhea** |
|  |  | **Known close contact with a person who is lab confirmed to have COVID-19** |
| If you checked **Yes** to any of the Above, Go Home and Call your Provider |
| **Y** | **N** | **Have you been tested or know someone that has been tested for COVID-19?** |
| **If YES, do you know the results?** \_\_\_\_\_Positive \_\_\_\_\_Negative |
| **If NO, do you know when the test was administered?** Date\_\_\_\_\_\_\_\_ |
| **DON’T KNOW, send the employee home.**  |
| If test was **Negative** or it has been more than 14 days since exposure **employee is clear to enter.** |