|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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.** | | | | | |