

Self Screening

BACKGROUND INFORMATION

Agency:	Date:	Time:
Completed by (name of screener):	Name of individual being screened:	

TEMPERATURE

<i>Use your no-touch thermometer to take employee's temperature. Is their temperature greater than or equal to 100.0 degrees Fahrenheit?</i>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
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CONTACTS

<i>Have you had any known close contact with a person confirmed or suspected to have COVID-19 in the past 14 days?</i>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
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SYMPTOMS

<i>Are you currently experiencing ANY of the following symptoms?</i>		
Cough (new or worsening)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Shortness of Breath (new or worsening)		
Troubled Breathing (new or worsening)		
Fever		
Chills		
Muscle Pain (new or worsening)		
Headache (new or worsening)		
Sore Throat (new or worsening)		
New Loss of Taste		
New Loss of Smell		

RESULTS

<i>Employee answers "NO" to <u>all</u> questions.</i>	<i>Employee answers "YES" to <u>any</u> question.</i>
<input type="checkbox"/> Passed	Do Not Attend Even

X _____

By signing the above i attest my answers are true and factual.