

COVID-19—EMPLOYEE SELF-SCREENING

Date: _____

Temperature at arrival for work: _____
(no-touch thermometer available at school entrance)

Employee Name: _____

Please complete the following questions, selecting an answer for each.

1. Have you experienced a fever, cough, sore throat, diarrhea, and/or had difficulty breathing in the past 10 days?
 No Yes
2. Within the last 24 hours have you had a body temperature of 100.4 F / 38C or greater?
 No Yes
3. Have you or a family member living with you traveled by airplane within the past 10 days?
 No Yes
4. Have you or a family member living with you traveled away from your primary residence within the past 10 days (other than to and from work, during work, or to provide necessary services for yourself or your family such as groceries, medical supplies, gas etc.)?
 No Yes
5. To your knowledge, have you been in close contact (within 6 feet for cumulative time of 15 minutes) with a person who has been confirmed positive for COVID-19 or is waiting for test results?
 No Yes
6. Have you or a family member living with you been instructed to self-quarantine within the past 10 days by a health care provider?
 No Yes

Note: If you answered “Yes” to any questions, please do not report to work, and alert an administrator immediately for further discussion.

By signing this form, I am agreeing that the above information is accurate.

Employee Signature

Date

Employee Name (Printed)