COVID-19 Workplace Health Screening

Company Name: ________________________________
Employee: ___________________________ Date: ______
Time In: ________

In the last 24 hours, have you experienced the new onset of any of the follow that are not due to another medical condition:

- Subjective fever (felt feverish): ☐ Yes ☐ No
- New or worsening cough: ☐ Yes ☐ No
- Shortness of breath or difficulty breathing: ☐ Yes ☐ No
- Chills: ☐ Yes ☐ No
- Headache: ☐ Yes ☐ No
- Sore throat: ☐ Yes ☐ No
- Loss of smell or taste: ☐ Yes ☐ No
- Runny nose or congestion: ☐ Yes ☐ No
- Muscle aches: ☐ Yes ☐ No
- Abdominal pain: ☐ Yes ☐ No
- Fatigue: ☐ Yes ☐ No
- Nausea: ☐ Yes ☐ No
- Vomiting: ☐ Yes ☐ No
- Diarrhea: ☐ Yes ☐ No

Current Temperature: __________________________

DISCLAIMER: This screening tool is subject to change based on the latest information on COVID-19.

If you answer “yes” to any of the symptoms listed above OR your temperature is 100.4°F or higher, please do not go into work. Self-isolate at home and contact your primary care physician’s office for direction.

- You should isolate at home for minimum of 10 days since symptoms first appear or per guidance of your local health department.
- If diagnosed as a probable COVID-19 or test positive, call your local health department and make them aware of your diagnosis or testing status.
- You must also have 24 hours without a fever and improvement in symptoms.

In the past 14 days, have you:

- Had close contact with an individual diagnosed with COVID-19? ☐ Yes ☐ No
- Traveled internationally? ☐ Yes ☐ No

If you answer “yes” to either of these questions, please do not go into work. Self-quarantine at home for 14 days. Contact your primary care physician’s office if you have symptoms or have had close contact with an individual for evaluation. If you are given a probable diagnosis or test positive call your local health department to ensure they are aware and have read through all the above statements and ensure everything is accurate.

Signature: ____________________________ Date: ________

For questions, visit www.bhsj.org. Contact the Branch-Hillsdale-St. Joseph Community Health Agency 517-279-9561.