

EMPLOYEE + VOLUNTEER PRE-WORK HEALTH CHECKLIST

IN THE PAST 24 HOURS, HAVE YOU EXPERIENCED ANY OF THE FOLLOWING:

- | | | |
|---|------------------------------|-----------------------------|
| Subjective Fever (feeling feverish/chills) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| New or worsening cough | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Shortness of breath | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sore throat | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Muscle pain | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| New loss of smell or taste | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Gastrointestinal symptoms- nausea, diarrhea | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If you answered **yes** to any of the above, or you have a temperature of **100 degrees or higher**:

PLEASE – DO NOT GO TO WORK/VOLUNTEER OR ENTER THE BUILDING.

Self-isolate at home and contact a physician or urgent care facility for further direction.

- Do not return to work/volunteer or enter the building until you have:
 - isolated at home for at least 7 days from the onset of symptoms; AND
 - no fever for at least 72 hours (that is three full days of no fever without the use of fever reducing medicine); AND
 - other symptoms have improved (for example, cough or shortness of breath, etc)

IN THE LAST 14 DAYS, HAVE YOU:

Been in “close contact” as defined by the CDC with a person diagnosed with COVID-19 Yes No

Traveled internationally? Yes No

If you answered **yes** to either question: **PLEASE – DO NOT GO TO WORK/VOLUNTEER OR ENTER THE BUILDING.** Self-quarantine at home.

My signature indicates that I have answered this form accurately and I understand/acknowledge the above expectations.

Signature

_____/_____
Date/Time

PRINT NAME

REASON FOR VISITING