Daily Health Screening Inventory

Regarding your personal health, please answer the following questions to the best of your ability:

Are you currently experiencing, or have you experienced within the past 10 days any of the following symptoms?

Fever (Temp equal to or greater than 100.4 F)	[ ] Yes [ ] No
Chills with shaking or teeth chattering	[ ] Yes [ ] No
Fatigue	[ ] Yes [ ] No
Muscle or body aches	[ ] Yes [ ] No
Congestion or runny nose	[ ] Yes [ ] No
Sore throat	[ ] Yes [ ] No
Frequent cough	[ ] Yes [ ] No
Shortness of breath at rest	[ ] Yes [ ] No
Nausea or vomiting	[ ] Yes [ ] No
Diarrhea	[ ] Yes [ ] No
Headache	[ ] Yes [ ] No
Loss of ability to taste or smell	[ ] Yes [ ] No

Are you awaiting COVID-19 test results, or have you been told to Isolate or Quarantine by a healthcare provider?

[ ] Yes [ ] No

Stop here and follow the directions at the bottom if you completed a full vaccination course at least 14 days ago; OR have been diagnosed with COVID 19 in the past 90 days.
If not, continue to the next two questions before submitting your responses.

Are you well, but a member of your household is sick at home with bronchitis-like or cold symptoms, or awaiting the result of a COVID-19 test?

[ ] Yes [ ] No

Have you been in direct close contact with a person with lab confirmed or suspected case of COVID-19 within the past 14 days?

[ ] Yes [ ] No

***Before arriving to work, notify your work center monitor via text or email of your response by indicating "I answered no to all questions," or, "I answered yes to at least one question."**

***If you answered yes to any of the above questions, DO NOT report to work. Stay home and consult your personal physician for further guidance.**