

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) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chills with shaking or teeth chattering | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fatigue | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Muscle or body aches | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congestion or runny nose | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Sore throat | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Frequent cough | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Shortness of breath at rest | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Nausea or vomiting | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diarrhea | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Headache | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Loss of ability to taste or smell | <input type="checkbox"/> Yes <input type="checkbox"/> 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 AND had a booster no more than six months (2 months for J&J) since the initial shot; 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.**