White Cloud Public Schools

Building a Tradition of Excellence

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Appendix E

COVID-19 Workplace Health Screening

Company/School Name: ______________________________

Employee: ______________________________ Date: ______________

Time In: ______________

1. In the last 14 days, have you developed any of the following symptoms that are new/different/worse from baseline of any chronic illness:

Symptom		
Subjective fever (felt feverish):	☐ Yes	☐ No
New or worsening cough:	☐ Yes	☐ No
Shortness of breath or difficulty breathing:	☐ Yes	☐ No

2. In the last 14 days, have you developed any of the following symptoms that are new/different/worse from baseline of any chronic illness:

Symptom		
Chills:	☐ Yes	☐ No
Headache:	☐ Yes	☐ No
Sore throat:	☐ Yes	☐ No
Loss of smell or taste:	☐ Yes	☐ No
Muscle aches:	☐ 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 in section 1, **OR YES** to two or more of the symptoms listed in section 2, **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 until you are fever free for at least 24 hours, your symptoms are improving, and it has been at least 10 days since symptoms first appeared or per guidance of your local health department or healthcare provider.
  - 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.

In the past 14 days, have you:

Question		
Had close contact with an individual diagnosed with COVID-19?	☐ Yes	☐ No
Have you been told by the health department or your healthcare provider to self-isolate or self-quarantine?		
Have you traveled internationally or taken a cruise?	☐ 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.

Signature: ______________________________ Date: ______________

For questions or more information, email info@dhd10.org | visit www.dhd10.org/coronavirus.