

# COVID-19 and our communities



## COVID-19 Workplace Health Screening

Company Name: \_\_\_\_\_

Employee: \_\_\_\_\_ Time In: \_\_\_\_\_ Date: \_\_\_\_\_

### 1. In the last 24 hours, have you experienced:

Subjective fever (felt feverish):	<input type="checkbox"/> Yes	<input type="checkbox"/> No
New or worsening cough:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Shortness of breath or difficulty breathing:	<input type="checkbox"/> Yes	<input type="checkbox"/> No

### 2. In the last 24 hours, have you experienced:

Chills:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Headache*:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sore throat:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Loss of smell or taste:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Runny nose or congestion*:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Muscle aches:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Abdominal pain:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fatigue:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Nausea:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Vomiting:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diarrhea*:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Current Temperature:		

*\*New or worsening symptoms outside of what individual defines as normal.*

If you answer "yes" to any of the symptoms listed above in section 1, at least two 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 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 3 days without fevers (without use of fever reducing medications) and improvement in respiratory symptoms.

### In the past 14 days, have you:

Had close contact with an individual diagnosed with COVID-19?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Traveled via airplane internationally or domestically?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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.

For questions, visit [www.saginawpublichealth.org/coronavirus](http://www.saginawpublichealth.org/coronavirus) or call the Saginaw County Health Department COVID-19 hotline (989) 758-3828.



May 6, 2020