Coronavirus Disease (COVID-19)
Workplace Health Screening

Facility Name: _____

Employee Name: _____ Date: _____

Management Signature: _____

In the past 24 hours, have you experienced:

Subjective fever (felt feverish):	☐ Yes	☐ No	Chills:	☐ Yes	☐ No
New or worsening cough:	☐ Yes	☐ No	Repeated Shaking with Chills:	☐ Yes	☐ No
Shortness of breath:	☐ Yes	☐ No	Muscle Pain:	☐ Yes	☐ No
Sore throat:	☐ Yes	☐ No	Congestion or Runny Nose:	☐ Yes	☐ No
Diarrhea:	☐ Yes	☐ No	Nausea or Vomiting:	☐ Yes	☐ No
Loss of Smell or Taste:	☐ Yes	☐ No			
Severe Fatigue:	☐ Yes	☐ No			

Current temperature: _____

If you answer **"yes"** to any of the symptoms listed above, or your temperature is **100.4ºF 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.
- You must also have 1 day without fever and improvement in all symptoms

In the past 14 days, have you:

Had close contact with an individual diagnosed with COVID-19? ☐ Yes ☐ No

Travelled internationally or outside of Michigan in the last 14 days, excluding commuting from a home location outside of Michigan? ☐ Yes ☐ No

If you answer **"yes"** to either of these questions, please do not go into work. If you have had close contact with a confirmed case, self-quarantine at home for 14 days. Contact your employer for direction regarding travel.

Are you/do you:

- Immunocompromised ☐ Yes ☐ No
- Need to care for someone with a confirmed diagnosis of COVID-19 ☐ Yes ☐ No
- Have a family care responsibility as a result of a government directive, e.g. child care due to schools or day-care being closed ☐ Yes ☐ No

For questions, visit https://ioniacounty.org/health/health-department/ or contact Ionia County Health Department at 616-527-5341.