COVID-19 Self-Assessment Form

Instructions for Individuals: *Complete Part One, including taking and recording your temperature and answering the "Yes" or "No" questions by checking the applicable box for each question. Complete Part Two and sign where indicated. Return the completed Form to* ***[insert]****.*

Part One

Employee Name:	**Department:**	
Date:	**Time:**	
Temperature reading on date and time indicated above *(insert in box to right)*:		
Questions (*check yes/no for each*)	**Yes**	**No**
In the past 14 days, have you experienced a *new or worsening cough* (excluding chronic cough due to asthma, known medical reasons, or allergies)?		
In the past 14 days, have you experienced shortness of breath or difficulty breathing?		
In the past 14 days, have you experienced any of the following: fever, chills, muscle pain, sore throat or new loss of taste or smell?		
In the past 14 days, have you experienced gastrointestinal problems, such as nausea and vomiting or diarrhea (excluding diarrhea due to known medical reason)?		
In the past 14 days, has any member of your household, any person for whom you provide care, or any intimate partner been diagnosed with or believed to have COVID-19?		
In the past 14 days have you have been within approximately 6 feet of a person confirmed or believed to have COVID-19 for a few minutes or more?		
In the past 14 days have you had direct contact with the bodily secretions of anyone diagnosed with or believed to have COVID-19 (e.g. being coughed on, touching used tissues with a bare hand, sharing food or drink, etc.)?		
In the past 14 days have you have travelled outside the state, excluding commuting from a home location outside of the state, and in particular internationally?		

Part Two

By completing the Form and signing below, you are certifying your responses are true and correct. You understand that if you are unable or unwilling to complete the Form, you will not be able to work on premises. If you believe circumstances permit you to return to work on premises without completing the Form, contact ***[insert]****.*

Please check the appropriate box:

- ☐ **I confirm all of my responses to the above questions are true for me on this date.**
- ☐ **I am unable to confirm that all of the above statements are true for me on this date.**

Signature:_______________________________________ Date:_______________________

Commented [A1]: This form would be used if the employee is taking the temperature themselves.

Commented [A2]: The CDC is regularly updating its list of symptoms. We would recommend the symptoms listed here be reviewed again just prior to implementation of the screenings to ensure compliance with current guidance.