

[Insert Parish/Mission Name] COVID-19 Screening

<input type="checkbox"/> Employee <input type="checkbox"/> Visitor	Name: _____
Date: _____	Time In: _____

In the past 24 hours, have you experienced:

Current Temperature: _____°F

Fever (felt feverish or above 100.4° F)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
New or worsening cough?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Shortness of breath?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sore throat?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Vomiting, Diarrhea, or Chills?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Muscle pain?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sudden loss of taste or smell?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If symptoms are due to a known, non-worsening chronic condition, mark “No”.

If you otherwise answer “Yes” to any of the symptoms listed above, please do not enter this work site, or leave the work site and return home. Self-quarantine at home and seek a COVID-19 test. Contact your physician’s office for testing information, or contact your local COVID-19 testing site. Stay home until you receive advice from a medical professional. If you are an employee of **[Insert Parish/Mission Name]**, contact **[Human Resources Name]** at **[phone]** or **[email]**.

In the past 14 days, have you:

Had close contact with a person who shows symptoms of, or has been diagnosed with, COVID-19?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Traveled outside Michigan Region 8 (Upper Peninsula)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Close contact? If “Yes”, please do not enter this work site, or leave the work site and return home. Self-quarantine at home for 14 days. If you are an employee of **[Insert Parish/Mission Name]**, contact **[Human Resources Name]** at **[phone]** or **[email]**.

Travel outside of Region 8 of Michigan? If you are an employee of **[Insert Parish/Mission Name]**, contact **[Human Resources Name]** at **[phone]** or **[email]**. **[You [may be / will be] excluded from in-person work for 14 days upon your return. -or- You [may be / will be] required to wear a mask during all in-person work for 14 days upon your return.]**

Office use: Retained in confidential file on _____ [date] by _____ [initials]

Form last updated: June 4, 2020