

COVID-19 SCREENING FORM FOR ALL TEAM MEMBERS

Thank you for your cooperation, patience and understanding.

By signing below, I acknowledge that in the last 14 days I have **not**:

- been in contact with someone diagnosed with or is suspected of having Coronavirus [COVID-19] or who has exhibited the symptoms below.
- been in a high risk area (in a crowded space without proper PPE).
- had an in-person appointment with a medical provider for prolonged exposure within 6 feet where the provider did not wear required PPE (gloves, gown, face mask and goggles or face shield).

In addition, if I have been tested in the last 14 days, the results were negative.

PLEASE INFORM THE PERSON SCREENING YOU IF YOU ARE EXPERIENCING ANY OF THE SYMPTOMS BELOW:

TEMPERATURE READING:

- Temperature of 100.4° F or greater
- Sore throat
- Congestion
- Cough
- Sneezing
- Shortness of breath
- Runny Nose
- Tightness in chest
- Loss of smell or taste
- Body aches

Check with your supervisor or the person in charge to determine what PPE you should wear in the building

NAME [please print]

SIGNATURE DATE

JOB TITLE [IF APPLICABLE] TIME

During the COVID-19 pandemic, this questionnaire is part of safety measures as recommended by our local and state health department, the CDC and CMS to protect the health and safety of the staff and residents. This screening form will be stored in a secure location.



To be completed by screener:
Employee First Name: _____ Last Name (Initial ONLY): _____

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