COVID-19 SCREENING FORM FOR ALL SUN HEALTH TEAM MEMBERS

Thank you for your cooperation, patience and understanding.

PLEASE CHECK ANY SYMPTOMS YOU ARE CURRENTLY EXPERIENCING:
Symptoms may appear 2-14 days after exposure to the virus.

- ☐ Temperature of 100.4° F or greater
- ☐ Headache
- ☐ Sore throat
- ☐ Congestion
- ☐ Runny nose
- ☐ Tightness in chest
- ☐ Loss of smell or taste
- ☐ Nausea or vomiting
- ☐ Fatigue
- ☐ Cough
- ☐ Sneezing
- ☐ Shortness of breath
- ☐ Muscle or body aches
- ☐ Diarrhea

TEMPERATURE READING: ____

☐ Yes ☐ No In the last 14 days outside of work ,I have been in contact with someone diagnosed with or who is suspected of having Coronavirus [COVID-19] or has exhibited symptoms.

If yes, ☐ I have contacted my supervisor regarding my exposure and have been approved to report to work.

☐ Yes ☐ No I have been tested outside of Sun Health in the last 14 days.

If yes, ☐ I have informed my supervisor.

Sun Health Team Members: Please notify your supervisor if you are symptomatic.
Check with your supervisor or the person in charge to determine what PPE you should wear in the building.

NAME [please print] _____ JOB TITLE [IF APPLICABLE] _____

SIGNATURE _____ DATE _____ 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.

By signing this form, I affirm my answers to these questions are accurate and true. If it is discovered that I falsified these answers, I can be subject to disciplinary action up to and including termination.

To be completed by screener:

My initials indicate that I have reviewed this form for any COVID concerns.
Screener Initials (Please Print): _____

Sun Health®
Revised on 02/01/2021

COVID-19 SCREENING FORM FOR ALL SUN HEALTH TEAM MEMBERS

Thank you for your cooperation, patience and understanding.

PLEASE CHECK ANY SYMPTOMS YOU ARE CURRENTLY EXPERIENCING:
Symptoms may appear 2-14 days after exposure to the virus.

- ☐ Temperature of 100.4° F or greater
- ☐ Headache
- ☐ Sore throat
- ☐ Congestion
- ☐ Runny nose
- ☐ Tightness in chest
- ☐ Loss of smell or taste
- ☐ Nausea or vomiting
- ☐ Fatigue
- ☐ Cough
- ☐ Sneezing
- ☐ Shortness of breath
- ☐ Muscle or body aches
- ☐ Diarrhea

TEMPERATURE READING: ____

☐ Yes ☐ No In the last 14 days outside of work ,I have been in contact with someone diagnosed with or who is suspected of having Coronavirus [COVID-19] or has exhibited symptoms.

If yes, ☐ I have contacted my supervisor regarding my exposure and have been approved to report to work.

☐ Yes ☐ No I have been tested outside of Sun Health in the last 14 days.

If yes, ☐ I have informed my supervisor.

Sun Health Team Members: Please notify your supervisor if you are symptomatic.
Check with your supervisor or the person in charge to determine what PPE you should wear in the building.

NAME [please print] _____ JOB TITLE [IF APPLICABLE] _____

SIGNATURE _____ DATE _____ 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.

By signing this form, I affirm my answers to these questions are accurate and true. If it is discovered that I falsified these answers, I can be subject to disciplinary action up to and including termination.

To be completed by screener:

My initials indicate that I have reviewed this form for any COVID concerns.
Screener Initials (Please Print): _____

Sun Health®
Revised on 02/01/2021