Appendix A



COVID-19 School Staff Health Self Screening

School District/Building: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date/Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. In the last 14 days, have you developed any of the following symptoms that are new/different/worse from baseline of any chronic illness:

|  |  |  |
| --- | --- | --- |
| Fever of 100.4**o**F or higher, or felt feverish: | ☐ Yes | ☐ No |
| New or worsening cough: | ☐ Yes | ☐ No |
| Shortness of breath or difficulty breathing: | ☐ Yes | ☐ No |

1. In the last 14 days, have you developed any of the following symptoms that are new/different/worse from baseline of any chronic illness:

|  |  |  |
| --- | --- | --- |
| Chills: | ☐ Yes | ☐ No |
| Headache: | ☐ Yes | ☐ No |
| Sore throat: | ☐ Yes | ☐ No |
| Loss of smell or taste: | ☐ Yes | ☐ No |
| Runny nose or congestion: | ☐ Yes | ☐ No |
| Muscle aches: | ☐ Yes | ☐ No |
| Abdominal pain: | ☐ Yes | ☐ No |
| Fatigue: | ☐ Yes | ☐ No |
| Nausea: | ☐ Yes | ☐ No |
| Vomiting: | ☐ Yes | ☐ No |
| Diarrhea: | ☐ Yes | ☐ No |
| Current Temperature: |  |  |

If you answer **YES** to any of the symptoms listed in section 1, **OR** **YES** to two or more of the symptoms listed in section 2, please do not go into work. Self-isolate at home and contact your primary care physician’s office for direction.

**You may return to work when:**

1. Your symptoms improve, **AND**
2. You have been fever-free for at least 24 hours without fever-reducing medication, **AND**
3. Any of the following apply:
   1. Another cause is identified for your symptoms by a healthcare provider, **OR**
   2. You test negative for COVID-19 with a diagnostic test, **OR**
   3. At least 10 days have passed since symptoms first appeared

In the past 10 days, have you:

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

If you answer **YES** to this questions, please do not go into work. Self-quarantine at home for 10 days. Contact your primary care physician’s office if you have symptoms or have had close contact with an individual for evaluation. If you are given a probable diagnosis or test positive call your local health department to ensure they are aware.

Signature: Date:

DISCLAIMER: This screening tool is subject to change based on the latest information on COVID-19

For more information, visit [www.barryeatonhealth.org/coronavirus](http://www.barryeatonhealth.org/coronavirus) or [www.michigan.cov/coronavirus](http://www.michigan.cov/coronavirus)

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