SHIAWASSEE COUNTY HEALTH DEPARTMENT
Promoting Wellness. Protecting Health.

**Coronavirus Disease (COVID-19) Workplace Screening**

Company Name: _____

Employee Name: _____ Date: _____

Time In: _____

**In the past 24 hours, have you experienced:**

| Symptoms | Yes | No |
|---|---|---|
| Subjective fever (felt feverish) | | |
| New or worsening cough | | |
| Shortness of breath | | |
| Sore throat | | |
| Chills or repeated shaking with chills | | |
| New loss of smell or taste | | |
| Headache | | |
| Muscle pain | | |

If you have answered **"yes"** to any of the symptoms listed above, or your temperature is **100.4 degrees Fahrenheit or higher**, please **do not** go into work. Self-isolate at home and contact your primary care physician's office for direction.

- You should isolate at home for a minimum of 7 days since symptoms first appeared.
- You must also have 3 days without fevers and improvement in respiratory symptoms.

**In the past 14 days, have you:**

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

Traveled via airplane internationally or domestically? ☐ Yes ☐ No

If you have answered **"yes"** to either of these questions, please do not go into work. Self-quarantine at home for 14 days.