# City of COVID-19 screening questionnaire

## For employees and visitors

Employees and visitors are to complete this questionnaire at the beginning of each shift where they are present at a city-controlled facility.

1. Do you have any of these symptoms that are not caused by another condition?

* Fever or chills
* Cough
* Shortness of breath or difficulty breathing
* Fatigue
* Muscle or body aches
* Headache
* Recent loss of taste or smell
* Sore throat
* Congestion
* Nausea or vomiting
* Diarrhea

2. Within the past 14 days, have you had contact with anyone that you know had COVID-19 or COVID-like symptoms? Contact is being 6 feet (2 meters) or closer for more than 15 minutes with a person, or having direct contact with fluids from a person with COVID-19 (for example, being coughed or sneezed on).

3. Have you had a positive COVID-19 test for active virus in the past 10 days?

4. Within the past 14 days, has a public health or medical professional told you to self-monitor, self-isolate, or self-quarantine because of concerns about COVID-19 infection?

If you have answered YES to any of the options in the first question, please return home.

If any of the above symptoms develop while at work, please notify your supervisor by email and go home. Contact [COVID program administrator or other personnel] to determine any action needed prior to returning to the office.