COVID-19 Employee Screening Questionnaire

As part of our efforts to prevent the spread of the coronavirus and reduce the risk of potential exposure for you, our students and your coworkers, you are required to complete this initial screening questionnaire and adhere to the following:

1. Complete the form and return it to the School Nurse. Your medical information will be kept confidential. Anonymized information may be shared on a need-to-know basis to warn others of potential exposure.
2. On a daily basis all employees are expected to evaluate their health status in light of the below criteria. We must be realistic and use best judgment in evaluating symptoms. If you experience a number of the symptoms in combination below or have a fever of 100.4 degrees or greater within the last 24-48 hours you must stay home.
3. The district reserves the right to take an employee's temperature. If presenting with a combination of symptoms below, the employee may be sent home. A physician's note may be required for the employee to return to work.
4. By utilizing your identification badge to check in daily, you are indicating you understand the procedure as outlined; are fever free and asymptomatic.

Please respond to each of the following initial questions truthfully and to the best of your ability. You will be asked to complete this form periodically throughout the year.

1. Have you tested positive for released from doctor's care? COVID-19 and have you not been released from doctor's care? ☐ YES ☐ NO
2. Have you, either currently and/or within the past 14 days, been in close proximity to anyone who has tested positive for COVID-19? ☐ YES ☐ NO
3. Have you, either currently or in the past 14 days, experienced any two of the following symptoms that has not been attributed to a non-covid related condition?

- Fever or chills ☐ YES ☐ NO
- Cough ☐ YES ☐ NO
- Shortness of breath or difficulty breathing ☐ YES ☐ NO
- Fatigue ☐ YES ☐ NO
- Muscle or body aches ☐ YES ☐ NO
- Headache ☐ YES ☐ NO
- New loss of taste or smell ☐ YES ☐ NO
- Sore throat ☐ YES ☐ NO
- Congestion or runny nose ☐ YES ☐ NO
- Nausea or vomiting ☐ YES ☐ NO
- Diarrhea ☐ YES ☐ NO
- Blood clots or unexplained vascular issues, including unusual swelling of extremities ☐ YES ☐ NO

If you have traveled outside the State of New Jersey within the past 14 days, did you travel to any of the states listed on the New Jersey travel advisory list found at *https://covid19.nj.gov/?*

Name _____ Signature _____ Date _____

Reviewed/Approved By (Print) _____ Signature _____

NOTE – please do not volunteer personal health information for any condition that is not COVID-19 related unless seeking disability accommodation. If you are quarantined, you may be eligible for up to 80 hours of paid time off under federal law. You may also use accrued sick, personal or vacation leave