Health Screening Form

The purpose of this questionnaire is for you to self-observe your health prior to coming to work. It was developed with criteria from the CDC.

Take your temperature every day before reporting to work. If your temperature is greater than 100.4 degrees F, or if you answer **YES** to the following questions, please stay home, call your supervisor and complete the COVID-19 Notification Form.

Please answer the following questions:		
1. Have you been tested for the coronavirus (awaiting results)? If yes, stay home until results are received	YES	NO
2. Have you tested **POSITIVE** for the coronavirus? If yes, stay home for 14 days after symptoms are gone.	YES	NO
3. Have you had prolonged close contact with someone who tested positive for the coronavirus? If Yes, stay home for 14 days and return to work if no symptoms.	YES	NO
4. Has a member of your household been tested for the coronavirus (awaiting results)? If Yes, stay home until results are received.	YES	NO
5. Has a member of your household been asked by a medical professional to isolate for potential coronavirus? If Yes, stay home pending results.	YES	NO
6. Has a household member had prolonged close contact with someone who tested positive for the coronavirus? If Yes, stay home for 14 days and return to work if there are NO symptoms.	YES	NO
7. Have you traveled out of the country within the last 14 days? If Yes, stay home for 14 days from your arrival back to the United States. Return to work if there are no symptoms.	YES	NO
8. Have you taken a cruise within the last 14 days? If Yes, stay home for 14 days from your arrival back to the United States. Return to work if there are no symptoms.	YES	NO
Are you experiencing or have you experienced any of the following symptoms in the past 14 days? If you answer YES to at least one of these questions, please stay home & call your healthcare provider.		
• Have you had a fever (greater than 100.4) in the last 24 hours without the use of fever-reducing medicines?	YES	NO
• Do you have shortness of breath or difficulty breathing?	YES	NO
• Do you have a new cough or sore throat?	YES	NO
• Are you experiencing repeated shaking with chills?	YES	NO
• Have you experienced a new loss of taste or smell?	YES	NO
• Are you ill or caring for someone who is ill?	YES	NO
• Do you have muscle pain? *	YES	NO
• Do you have a headache? *	YES	NO

*If answering yes, care should be taken before reporting to work if combined with other symptoms. If answering yes to other questions (or otherwise showing symptoms that may be related to COVID-19) please stay home, call your supervisor and complete the COVID-19 Notification Form. You may be asked to self-isolate until they are free of fever for three consecutive days without fever-reducing medication and 10 days since the onset of symptoms unless you have a doctor's clearance for work or a negative COVID-19 test.

Once you begin your workday, continue to observe yourself for any changes such as fever, coughing and/or difficulty breathing.

What to do if your condition changes while at work or at home:

Inform your supervisor and complete the COVID-19 Notification Form.
Go home immediately and seek immediate guidance from your healthcare provider.

Please contact humanresources@acu.edu with any questions or concerns.

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