**COVID-19 SCREENING FORM (Staff)**

**Please complete this form to assess your potential exposure to or diagnosis of COVID-19 or other illnesses.**

Staff Member Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. State: \_\_\_\_\_\_\_\_. Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| QUESTION | YES | NO |
| Do you have a family or household member diagnosed with the COVID-19 virus currently or in the past? |  |  |
| Have you had any of the following symptoms in the past two weeks? |  |  |
| * Fever (100.4 or greater)
 |  |  |
| * Cough
 |  |  |
| * Shortness of breath or difficulty breathing
 |  |  |
| * Shaking chills
 |  |  |
| * Chest pain, pressure, or tightness
 |  |  |
| * Fatigue or difficulty with exercise
 |  |  |
| * Loss of taste or smell
 |  |  |
| * Persistent muscle aches or pains
 |  |  |
| * Sore Throat
 |  |  |
| * Nausea, vomiting, or diarrhea
 |  |  |
| * New uncontrolled cough that causes difficulty breathing (for individuals with chronic allergic/asthmatic cough, a changed in their cough from baseline)
 |  |  |
| Do you have moderate to severe asthma, a heart condition, diabetes, or a weakened immune system? |  |  |

Have you been diagnosed or tested positive for COVID-19 infection?

 ( ) YES ( ) NO DATE OF TEST: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

If you had COVID-19 infection,

* During the infection, did you suffer from chest pain, pressure, tightness or heaviness, or experience difficulty breathing or unusual shortness of breath?

 ( ) YES ( ) NO

* Since the infection, have you had new chest pain or pressure with exercise, new shortness of breath with exercise, or decreased exercise tolerance?

 ( ) YES ( ) NO

* **Should any of your information/answers change, please notify the school’s administration IMMEDIATELY.**

Staff Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_