COVID-19 Screening Form

Name_____ Employee #/DOB: _____

Phone Number_____

Please check any of the following symptoms you are currently experiencing:

- ☐ Fever >100.3 degrees Fahrenheit or chills
- ☐ Shortness of breath, difficulty breathing
- ☐ Chest pressure
- ☐ Muscle pain
- ☐ New loss of taste or smell
- ☐ Runny Nose/Nasal Congestion
- ☐ Cough
- ☐ Sore throat
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Dizziness, lightheadedness, or headaches
- ☐ Other active medical problems:

_____

Have you been ill recently, or have you been caring for someone who is ill?

☐ YES

☐ NO

Have you been in close contact with someone who has tested positive for Coronavirus (COVID-19)? Close contact is defined as being within 6 feet of a known or suspected COVID-19 individual for 10 minutes or more, or direct contact with respiratory secretions of a person with a confirmed COVID-19.

☐ YES

☐ NO

Have you traveled outside of the state of Alaska OR internationally OR had close contact with someone who traveled outside of AK or internationally (including travel on a cruise ship), within the past 14 days?

☐ YES

☐ NO

Have you visited a medical care facility (including long term healthcare facility), conducted first responder activities (ambulance service, etc.), or provided other patient care within the past 14 days?

☐ YES

☐ NO

Current Body Temperature (taken by Medical Personnel): _____°F

Would you like to be seen by a medical provider (Yes or No)? _____

I certify that my answers on this questionnaire are true and accurate to the best of my knowledge.

_____ _____

Signature **Date**

_____ _____

Medical Personnel Signature **Date**