COVID-19 Self-Assessment Questionnaire

The purpose of this questionnaire is for you to self-observe your daily health prior to coming to work. Once you begin your workday, continue to observe yourself for any changes. This questionnaire was developed with criteria from the CDC.

Please answer the following questions once you begin your workday. You should also take your temperature every day before reporting to work and write it down. **If your temperature is greater than 100° F, or if you answer YES to any of the following questions, please stay home and call your supervisor.**

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
9	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 and call your healthcare provider.	YES	NO
10	Cough (not related to allergies)	YES	NO
11	Shortness of breath	YES	NO
12	Difficulty breathing	YES	NO
13	Fever	YES	NO
14	Chills	YES	NO
15	Repeated shaking with chills	YES	NO
16	Muscle pain	YES	NO
17	New loss of taste or smell	YES	NO
18	Sore throat or headache	YES	NO

Participant Name: ____________________ **Date:** __________ **Temperature:** _____