



Coronavirus (COVID-19) **EMPLOYEE & 3rd Party Providers** Signs & Symptoms Screening

Name: _____ Date: _____

Best Contact Number: (_____) _____

3rd Party Provider Company Name (if applicable): _____

- 1) Did you or someone you are in close contact with have congregate travel (i.e. airplane, train, cruise boat, etc.) in the last 14 days? YES NO (skip to #2)

If YES, you must wear a N95 mask covered by a surgical mask or face shield until a negative COVID-19 PCR test result can be obtained after 5-7 days from your last day of potential exposure. Failure to comply may result in disciplinary action up to and including termination.

- 2) Have you or someone you are in close contact with tested positive for COVID-19 in the last 14 days? YES NO

If YES, you are restricted from entering until a negative COVID-19 PCR test result can be obtained after 5-7 days from your last day of exposure.

- 3) Please list all healthcare facilities, including hospitals, emergency rooms, long-term care facilities, senior living communities, outpatient treatment facilities, hospices and home health agencies, that you and those you are in close contact with have worked in/for or visited the last 14 days:

- 4) Do any of healthcare facilities you listed above have active COVID-19 tested positive for the Coronavirus in the last 14 days? YES NO

If YES, you must wear a N95 mask covered by a surgical mask or face shield until a negative COVID-19 PCR test result can be obtained after 5-7 days from your last day of potential exposure. Failure to comply may result in disciplinary action up to and including termination.

MUST Complete Reverse Side

5) Are you experiencing any of the following symptoms:

- a. Cough YES NO
b. Shortness of breath or difficulty breathing YES NO
c. Fever or chills (*current temperature is: _____*) YES NO
**fever is considered 99.5 degrees or above*

Also, please list any medications taken within the last 24 hours that may lower your temperature (Tylenol, NSAIDs, Aspirin or any cold medications):

- _____
d. Fatigue YES NO
e. Muscle or body aches YES NO
f. Headache YES NO
g. Sore throat YES NO
h. Congestion or runny nose YES NO
i. Nausea or vomiting YES NO
j. Diarrhea YES NO
k. New loss of taste or smell YES NO

If YES to any, a rapid Abbott COVID-19 test may be administered (as available). Regardless of the rapid test results, you are restricted from entering until a negative COVID-19 PCR test result can be obtained.

- 6) Have you used hand sanitizer upon entering the community? YES NO

REMINDER: If the Community is on the RED LEVEL, all employees and 3rd party providers must wear a N95 mask covered by a surgical mask or face shield at all times.

Agreement of Understanding

By signing below, I hereby certify that:

- All my answers and statements in this Signs & Symptoms Screening & Acknowledgement are true to the best of my knowledge and belief;
- I will adhere to the COVID-19 testing guidelines set forth by Cedarhurst; and
- Comply with **proper infection control procedures**, including **handwashing and cough etiquette**,
- Failure to follow the above may result in disciplinary action up to and including termination.

Employee Signature Date: _____

Employee Printed Name

Cedarhurst Screener Signature Date: _____

Cedarhurst Screener Printed Name