



Coronavirus (COVID-19) **EMPLOYEE** Signs & Symptoms Screening

All persons 15 years or under are RESTRICTED from entering the Community.

Name: _____ Date: _____

Best Contact Number: (_____) _____

- 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

If YES, you are restricted from entering until a negative COVID-19 test result can be obtained after returning for a minimum of 7 days, or for a minimum of 14 days after you or your close contact returned and are confirmed as not having any signs or symptoms of the Coronavirus (COVID-19) for at least 72 hours.

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

If YES, you are restricted from entering until a negative COVID-19 test result can be obtained after 7 days of exposure, or for a minimum of 14 days after you or your close contact are no longer positive for the Coronavirus (COVID-19) and are free from any signs or symptoms of COVID-19 for at least 72 hours.

- 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 are restricted from entering until a negative COVID-19 test result can be obtained after 7 days of potential exposure or a minimum of 14 days after your last visit from the healthcare facility and are free from any signs or symptoms of the Coronavirus (COVID-19) for at least 72 hours.

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. New loss of taste or smell YES NO

If YES to any, you are restricted from entering until a negative COVID-19 test result can be obtained, or for a minimum of 14 days and you are free from any signs or symptoms of the Coronavirus (COVID-19) for at least 72 hours.

6) Please note any other special circumstances or considerations:

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; and
- Failure to follow **proper infection control procedures**, including **handwashing and cough etiquette**, may result in disciplinary action up to and including termination.

Employee Signature

Date: _____

Employee Printed Name

Date: _____

Cedarhurst Screener Signature

Date: _____

Cedarhurst Screener Printed Name

Date: _____