**SAMPLE**

**Employee Health Screening & Reporting Agreement**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby agree that I will not come into work if I have **any** of the following symptoms and/or meet any of the following criteria.

I further agree to disclose to my employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ if I have **any** of the following symptoms or meet **any** of the following criteria:

1. I have been instructed to isolate or quarantine due to possible COVID-19 exposure.
2. I have had contact with any person with suspected or known COVID-19 in the last 14 days.
3. I currently have or have had **any** of the following symptoms in the last 24 hours.

* Cough
* Shortness of breath or difficulty breathing
* Fever at or above 100.4 °F
* Chills
* Repeated shaking with chills
* Muscle pain
* Headache
* Sore throat
* New loss of taste or smell

**I acknowledge that I have read, understood, and agree to be bound by the terms and conditions as outlined herein.**

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Signature |  | Date |

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| --- | --- | --- | --- | --- | --- |
| **Daily Illness Self-Screening Questions:**   1. Have I been instructed to isolate or quarantine due to possible COVID-19 exposure? 2. Have I had contact with any person with suspected or known COVID-19 in the last 14 days? 3. Have I had any of the following symptoms of COVID-19 in the   last 24 hours?   |  |  | | --- | --- | | * Cough * Shortness of breath or difficulty breathing * Chills * Repeated shaking with chills | * Fever ≥ 100.4 °F * Muscle pain * Headache * Sore throat * New loss of taste or smell |   If I answer “Yes,” to any of the three questions, I will not report to work. If I am experiencing COVID-19 symptoms, I will report this illness to my employer and call the **Mono Nurse Hotline at 211**. | **Daily Illness Self-Screening Questions:**   1. Have I been instructed to isolate or quarantine due to possible COVID-19 exposure? 2. Have I had contact with any person with suspected or known COVID-19 in the last 14 days? 3. Have I had any of the following symptoms of COVID-19 in the   last 24 hours?   |  |  | | --- | --- | | * Cough * Shortness of breath or difficulty breathing * Chills * Repeated shaking with chills | * Fever ≥ 100.4 °F * Muscle pain * Headache * Sore throat * New loss of taste or smell |   If I answer “Yes,” to any of the three questions, I will not report to work. If I am experiencing COVID-19 symptoms, I will report this illness to my employer and call the **Mono Nurse Hotline at 211**. |
| **Daily Illness Self-Screening Questions:**   1. Have I been instructed to isolate or quarantine due to possible COVID-19 exposure? 2. Have I had contact with any person with suspected or known COVID-19 in the last 14 days? 3. Have I had any of the following symptoms of COVID-19 in the   last 24 hours?   |  |  | | --- | --- | | * Cough * Shortness of breath or difficulty breathing * Chills * Repeated shaking with chills | * Fever ≥ 100.4 °F * Muscle pain * Headache * Sore throat * New loss of taste or smell |   If I answer “Yes,” to any of the three questions, I will not report to work. If I am experiencing COVID-19 symptoms, I will report this illness to my employer and call the **Mono Nurse Hotline at 211**. | **Daily Illness Self-Screening Questions:**   1. Have I been instructed to isolate or quarantine due to possible COVID-19 exposure? 2. Have I had contact with any person with suspected or known COVID-19 in the last 14 days? 3. Have I had any of the following symptoms of COVID-19 in the   last 24 hours?   |  |  | | --- | --- | | * Cough * Shortness of breath or difficulty breathing * Chills * Repeated shaking with chills | * Fever ≥ 100.4 °F * Muscle pain * Headache * Sore throat * New loss of taste or smell |   If I answer “Yes,” to any of the three questions, I will not report to work. If I am experiencing COVID-19 symptoms, I will report this illness to my employer and call the **Mono Nurse Hotline at 211**. |