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 _____

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**.