COVID-19 Daily Self Checklist

Employees

Instructions:

- You are required to complete this checklist each day before reporting to work.
- If you answer YES to any of the questions below, STAY HOME and immediately contact your supervisor. You will not be permitted to return to work until you meet all return-to work criteria or your physician has released you to return to work, whichever is applicable. If you are experiencing COVID-19 symptoms, you are directed to consult your medical provider to obtain a diagnosis and treatment. You must provide the District with documentation of your visit to your physician and documentation regarding any period of quarantine directed by your physician or Public Health Department.
- If you answer NO to the questions below, you will report work. By reporting to work, you are certifying you conducted the health check and answered NO to all the questons below.
- Note: If you previously tested positive for COVID-19 in the last three months, and recovered, you do not need to answer the questions marked with a "♦". The three month period is calculated from the date of your first onset of symptoms or, if you were asymptomatic, the date your testing specimen was collected.
- If you start feeling sick while at work or experiencing the symptoms listed below, report your symptoms to your supervisor immediately.

Question	Yes	No
Do you have a temperature of 100.4°F or greater?	☐	☐
Are you taking fever-reducing medicines, such as those that contain aspirin, ibuprofen or acetaminophen, in order to reduce your fever?	☐	☐
♦ Have you had close contact or cared for someone with COVID-19 within the past 14 days?	☐	☐
♦ Have you returned from travel outside the United States or on cruise ship or river boat within the past 14 days?	☐	☐
Have you been directed to self-quarantine by a health care provider?	☐	☐
Have you been directed to self-quarantine by the County or State Department of Public Health?	☐	☐
♦ Is an individual within your household currently being evaluated for COVID-19 symptoms or waiting on the results of a COVID-19 test?	☐	☐
Are you experiencing any of the following symptoms?		
• Chills	☐	☐
• Cough	☐	☐
• Shortness of breath or difficulty breathing	☐	☐
• Fatigue	☐	☐
• Muscle or body aches	☐	☐
• Headache	☐	☐
• New loss of taste or smell	☐	☐
• Sore Throat	☐	☐
• Congestion or runny nose	☐	☐
• Nausea	☐	☐
• Vomiting	☐	☐
• Diarrhea	☐	☐