Check-In Time: ______________ Date: _______________
Temperature: ____________ Training Completed: ❑ Yes ❑ No
Mask Issued: ❑Cloth ❑Medical Grade ❑Own (personal)mask

Screener Name (print)**:** ___________________________________ **Screener Signature:** ____________________________________

Office of Human Resources

Check One: ❑ Employee ❑Student ❑Contractor ❑Vendor ❑Other__________________________________
Area Visiting/Working: ❑ Business Office ❑HR ❑Bookstore ❑IT ❑Library ❑Learning Lab ❑Cyber Lab
Student Services: ❑Admissions ❑Advising ❑Financial Aid ❑Testing
Building: ❑A ❑B ❑C ❑D ❑E ❑F ❑G ❑H ❑J ❑K ❑M ❑N ❑S ❑T Other Location: ____________

Print Name: ____ Employee/Student ID: __________________
Email Address: ____Phone: ______________________________

1. Are you ill or caring for someone who is ill? ❑Yes ❑No

2. I affirm that I have not had fever for at least (3) days and have not taken fever reducing medication during this time. ❑Yes ❑No

3. Do you have any of the following symptoms?
   - ❑ Cough
   - ❑ Chills
   - ❑ Headache
   - ❑ Muscle Pain
   - ❑ Sore Throat
   - ❑ Loss of Taste or Smell
   - ❑ Diarrhea
   - ❑ Shortness of Breath or Difficulty Breathing
   - ❑ Repeated Shaking with Chill
   - ❑ Feeling feverish or a measured temperature greater than or equal to 100.0 degrees Fahrenheit
   - ❑ Known close contact with a person who has been lab confirmed within the past 14 days to have COVID-19
   - ❑ None of the above

4. Will you require an accommodation because of one or more of the following high risk categories? ❑Yes ❑No
   - ❑ 65 or older
   - ❑ Chronic Lung Disease
   - ❑ Asthma
   - ❑ Chronic Heart Disease
   - ❑ Severe Obesity
   - ❑ Diabetes
   - ❑Chronic Kidney Disease Undergoing Dialysis
   - ❑ Liver Disease
   - ❑ Weakened Immune System
   - ❑ None of the above

Complete Only if EE/Student returns after exhibiting symptoms:

5. Date Employee was sent home: ________________ Date Employee Returned to Work**:** __________________
6. My respiratory symptoms (cough and shortness of breath) have improved. ❑Yes ❑No ❑N/A
   Date respiratory symptoms began improving: ___________________________________
7. At least ten days have passed since my fever and/or respiratory symptoms began ❑Yes ❑No ❑N/A
   Date fever and/or respiratory symptoms began: _______________________

An employee sent home with a fever can return to work when:

- He or she has had no fever for at least three days without taking medication to reduce fever during that time; AND
- Any respiratory symptoms (cough and shortness of breath) have improved; AND
- At least ten days have passed since symptoms began.
- The employee may return to work earlier if a doctor confirms the cause of the employee's fever or other symptoms is not COVID-19 and provides a written release for the employee to return to work.

Signature ____ **Date:** ______________________________________