HEALTH SCREENING CHECKLIST

DAILY COVID-19 HOME RESOURCE FOR STUDENTS & EMPLOYEES

PART 1 QUESTIONS:		YES	NO
 Have you developed any of the following something: Shortness of breath/trouble breathing? New loss or sense of taste or smell? 	9 in last 14 days? 9 by a health care provider in the last 10 days?		
OP If YES to any question in Part 1, YOU	SHOULD STAY HOME. If NO to all questions in Part 1, p	roceed	to Part 2.
PART 2 QUESTIONS: • Have you developed any of the following so that the following so the followi	Nausea (sick to stomach) or vomiting	YES	NO
Headache Unusual fatigue Diarrhea	Fever (≥100.0°F) or chills (would indicate fever) Runny nose or nasal congestion Muscle or body aches		
Unusual fatigue	Runny nose or nasal congestion Muscle or body aches		



However, they do not necessarily indicate the need to test for COVID-19 or for COVID-19 isolation.

EHS