DATE_____

TIME_____ TEMP_____

You must wear a mask before entering the building

EMPLOYEE NAME_____

Please read each question carefully and circle the answer that applies. No health information or questionnaire answers will be shared with anyone outside of this organization.

Have you experienced any of the following symptoms of COVID-19 within the last 48 hours?

Fever Chills	Yes	No
Cough	Yes	No
Shortness of breath of difficulty breathing	Yes	No
Fatigue	Yes	No
Muscle or body aches	Yes	No
Headache	Yes	No
New loss of taste or smell	Yes	No
Sore throat	Yes	No
Congestion or runny nose	Yes	No
Nausea or vomiting	Yes	No
Diarrhea	Yes	No
Have you tested positive for COVID-19 in the past 10 days?	Yes	No
Are you currently awaiting results from a COVID-19 Test?	Yes	No
Have you been diagnosed with COVID-19 by a licensed healthcare provider (for example, a doctor, nurse, pharmacist, or other) in the past 10 days?	Yes	No
Have you been told that you are suspected to have COVID-19 by a licensed healthcare provider in the past 10 days?	Yes	No

If any of the above are answered **YES**, contact the Nursing Supervisor immediately for further assessment.

Daily monitoring for potential COVID-19 symptoms is important to track your current health status. If you experience new symptoms, consider seeing your healthcare provider or getting a test for COVID-19, especially where you may have had potential exposure to COVID-19.

You should also monitor your health and consider consulting your primary care physician after testing positive for COVID-19.

You **MUST** inform you supervisor if you:

* Receive a confirmed positive COVID-19 test result
* Have been diagnosed with COVID-19 by a licensed healthcare provider;
* Have been told you are suspected to have COVID-19 by a licensed healthcare provider;
* Experienced new loss of taste and/or smell with no other explanation; or
* Experience both fever ($\geq$ 100.4°F) and new unexplained cough associated with shortness of breath.

You may also contact Riverview's Infection Preventionist, Jennifer Parkinson, RN, BSN, WCC with this information or other COVID-19 Questions or Concerns. Ext. 4039 or jparkinson@co.ottawa.oh.us

Per policy please notify the facility immediately if you show signs/symptoms of respiratory illness/infection or fever for up to 14 days following your last exposure to our facility, staff or residents.

Signature of Employee: _____

Signature of Screener: _____

If your temp is 99* or above a nursing supervisor will be called to retake your temperature with another thermometer for accuracy. If still 99° F further instruction may be given including a COVID-19 rapid test.

If Supervisor was contacted what further action was taken: _____

_____

_____

_____

_____

Supervisor Signature: _____

DATE_____

TIME_____ TEMP_____

You must wear a mask before entering the building

VISITOR NAME_____

PHONE NUMBER: _____ Resident/Staff Member you are visiting: _____

Please read each question carefully and circle the answer that applies. No health information or questionnaire answers will be shared with anyone outside of this organization.

Have you experienced any of the following symptoms of COVID-19 within the last 48 hours?

Fever Chills	Yes	No
Cough	Yes	No
Shortness of breath of difficulty breathing	Yes	No
Fatigue	Yes	No
Muscle or body aches	Yes	No
Headache	Yes	No
New loss of taste or smell	Yes	No
Sore throat	Yes	No
Congestion or runny nose	Yes	No
Nausea or vomiting	Yes	No
Diarrhea	Yes	No
Have you tested positive for COVID-19 in the past 10 days?	Yes	No
Are you currently awaiting results from a COVID-19 Test?	Yes	No
Have you been diagnosed with COVID-19 by a licensed healthcare provider (for example, a doctor, nurse, pharma-cist, or other) in the past 10 days?	Yes	No
Have you been told that you are suspected to have COVID-19 by a licensed healthcare provider in the past 10 days?	Yes	No

If any of the above are answered **YES**, contact the Nursing Supervisor immediately for further assessment.

Daily monitoring for potential COVID-19 symptoms is important to track your current health status. If you experience new symptoms, consider seeing your healthcare provider or getting a test for COVID-19, especially where you may have had potential exposure to COVID-19.

You should also monitor your health and consider consulting your primary care physician after testing positive for COVID-19.

Please notify the facility immediately if you experience any of the following for up to 14 days following your last exposure to our facility, staff or residents.

* Show signs/symptoms of respiratory illness/infection or fever
* Receive a confirmed positive COVID-19 test result
* Have been diagnosed with COVID-19 by a licensed healthcare provider;
* Have been told you are suspected to have COVID-19 by a licensed healthcare provider;
* Experienced new loss of taste and/or smell with no other explanation; or
* Experience both fever (≥ 100.4°F) and new unexplained cough associated with shortness of breath.

You may contact Riverview's Infection Preventionist, Jennifer Parkinson, RN, BSN, WCC with this information or other COVID-19 Questions or Concerns. Ext. 4039 or jparkinson@co.ottawa.oh.us

Signature of Visitor: _____

Signature of Screener: _____

If your temp is 99* or above a nursing supervisor will be called to retake your temperature with another thermometer for accuracy.

If your temp is 100* or above, you will be directed to leave the facility and will be contacted by our facility Infection Preventionist or her designee.

If Supervisor was contacted what further action was taken: _____

_____

_____

_____

_____

Supervisor Signature: