Unit Level Medical Screening Questionnaire

Unit: Date:

Member Name/Rank:

1. Are you feeling sick today? Yes No

Specifically have you had any of the following: **Fever or Chills; Cough; Shortness of Breath; Fatigue; muscle or body aches; Headache; sore throat; loss of taste or smell; congestion or runny nose; any other physical symptoms**.

2. Have you felt sick in the last 48 hours? Yes No

   If Yes, when?

3. When was you last day of work?

4. Have you been in close contact with anyone who has tested positive for COVID in the last 14 Days?

   Yes No

   If Yes;

   When?

   Where?

   Result?

5. Have you been tested for COVID in the last 14 days because you were sick or in prolonged close contact with a positive COVID case?

   Yes No

   If Yes;

   When?

   Where?

   Result?

If you answered "Yes" to any of the questions above, please **do not come into work today** and contact PH for additional guidance.

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