

COVID-19 Screening Form

The safety of our employees remains The Arc’s overriding priority. As the COVID-19 outbreak continues to evolve and spread globally, The Arc will monitor the situation closely and will update agency guidance based on current recommendations from the Center for Disease Control, DDA and our local health departments.

To prevent the spread of COVID-19 and reduce the potential risk of exposure to our workforce, we are conducting a simple screening questionnaire. Your participation is important to help us take precautionary measures to protect you and everyone in the building. Thank you for your time.

Employee Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Personal Phone Number (optional): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supervisor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Job Site/location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- |
|  | YES | NO |
| Have you traveled outside Maryland within the last 14 days? |  |  |
| Have you had close contact with or cared for someone diagnosed with COVID-19 within the last 14 days? |  |  |
| Have you been in close contact with anyone who has traveled within the last 14 days? |  |  |
| Were you tested for COVID-19 while on leave? If “yes” do you have negative results? |  |  |
| Have you been asked to self-quarantine? |  |  |
| Do you have a secondary job? |  |  |
| Have you experienced any cold or flu-like symptoms in the last 14 days? (fever, cough, sore throat, respiratory illness, difficulty breathing, shortness of breath, chill, muscle pain, headache, nausea, vomiting, diarrhea, new loss of taste or smell) |  |  |

Manager, If the answer is “yes” to any of the questions, access to the facility may be denied pending further evaluation. Please send the completed form to Charlene Yates via email: cyates@arcsomd.org

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| Comments |
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Signature of person conducting screen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

H.R. Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nurse Signature (when applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_