DESERT ROSE ACADEMY

EMPLOYEE HEALTH SCREENING QUESTIONNAIRE

1. Since your last day of work, have you had any of the following CDC-recognized COVID-19 symptoms?

[ ] YES / [ ] NO	Fever, defined as a temperature at or above 100.4 degrees Fahrenheit (F)?
[ ] YES / [ ] NO	Cough
[ ] YES / [ ] NO	Shortness of breath or difficulty breathing
[ ] YES / [ ] NO	Chills
[ ] YES / [ ] NO	Fatigue
[ ] YES / [ ] NO	Muscle or body aches
[ ] YES / [ ] NO	Headache
[ ] YES / [ ] NO	Sore throat
[ ] YES / [ ] NO	New loss of taste or smell
[ ] YES / [ ] NO	Congestion or runny nose
[ ] YES / [ ] NO	Nausea or vomiting
[ ] YES / [ ] NO	Diarrhea
[ ] YES / [ ] NO	Any other COVID-19-related symptom identified by the CDC or Arizona Department of Health Services (ADHS)

If you answered "YES" to any of these symptoms, list each applicable symptom and identify: (a) the date each symptom began, and (2) the date each symptom subsided (or if ongoing, indicate "ongoing"):

_____

_____

For each identified symptom, do you have any explanation for the identified symptom other than a potential COVID-19 infection? [ ] YES / [ ] NO

If the answer is "YES," please list the symptom and the possible explanation:

_____

_____

2. Since your last day of work, have you:

[ ] YES / [ ] NO	Received a confirmed diagnosis of COVID-19 or tested positive for COVID-19?
[ ] YES / [ ] NO	Been advised to self-quarantine by a medical professional or public health official?

3. Since your last day of work, have you been in close contact with anyone who:

[ ] YES / [ ] NO	Tested positive for or has been diagnosed with COVID-19?
[ ] YES / [ ] NO	Has or had COVID-19 symptoms?