

Anchor Bay School District COVID-19 Daily Screening Protocol Questionnaire

loday's i	Date:////				
Please ch	eck the appropriate box:				
Em	ployee				
Visi	tor				
Name (Fi	rst and Last):				
Building:			_		
Do you h	ave any of the following sympton	ms?			
• Fever	of 100.4 degrees or higher	Yes	No		
• Chills		Yes			
	(other than known medical reason)				
 Difficu 	Ity breathing/shortness of breath	Yes	No		
Do you h	ave at least <u>two</u> of the following	symptoms:			
Chills					
☐ Repeat	ed shaking with chills				
☐ Muscle	pain				
☐ Heada	che				
☐ Sore T	hroat				
☐ New Io	ss of taste or smell				
☐ Diarrhe	ea (excluding diarrhea due to known	medical reason)			
☐ Extrem	ne fatigue				
☐ I am n	ot experiencing any of these sympton	ms.			
	knowledge, have you been expos ted to have COVID-19?	sed to someone v	vho has tested po	sting for C	OVID-19 o
Ye	es No				
Have you	ı traveled outside of Michigan in	within the last 1	.4 days?	_ Yes	No
hand sani issue whe always pra	and that I must use the designated entizer upon entering. I must wear a fain entering and anytime I am in share actice safe social distancing when in the me and if I work in an office I must	ice mask/ covering ed work areas, hall the workplace. I ur	unless prohibited b ways or when work nderstand that clear	y a documen ing with othe ning supplies	ited medical ers. I must
\square I und	erstand the statement above	-	,		
	and that if I begin to experience the someone in th	symptoms of COVII	D-19 or test positive	I am to not	ify my
☐ I und	erstand the statement above				

After submitting this form contact your immediate supervisor to be cleared.