



Anchor Bay School District COVID-19 Daily Screening Protocol Questionnaire

Today's Date: ____/____/____

Please check the appropriate box:

____ Employee

____ Visitor

Name (First and Last): _____

Building: _____

Do you have any of the following symptoms?

- Fever of 100.4 degrees or higher _____ Yes _____ No
- Chills _____ Yes _____ No
- Cough (other than known medical reason) _____ Yes _____ No
- Difficulty breathing/shortness of breath _____ Yes _____ No

Do you have at least **two** of the following symptoms:

- Chills
- Repeated shaking with chills
- Muscle pain
- Headache
- Sore Throat
- New loss of taste or smell
- Diarrhea (excluding diarrhea due to known medical reason)
- Extreme fatigue
- I am not experiencing any of these symptoms.

To your knowledge, have you been exposed to someone who has tested positive for COVID-19 or is suspected to have COVID-19?

____ Yes _____ No

Have you traveled outside of Michigan in within the last 14 days? _____ Yes _____ No

I understand that I must use the designated entry when reporting for work. I must wash my hands/ use hand sanitizer upon entering. I must wear a face mask/ covering unless prohibited by a documented medical issue when entering and anytime I am in shared work areas, hallways or when working with others. I must always practice safe social distancing when in the workplace. I understand that cleaning supplies are available to me and if I work in an office I must wipe down my workstation twice per day.

I understand the statement above

I understand that if I begin to experience the symptoms of COVID-19 or test positive I am to notify my supervisor immediately.

I understand the statement above

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