

COVID-19 Screening Questionnaire

Name: _____

*All workers who meet any two or more of the following criteria should be evaluated as a person under investigation for **COVID-19***

Recent Travel History

Any recent foreign travel? **Yes** **No**

If yes where _____

Any travel to the **HIGH RISK AREAS?** (New Orleans, NY, NJ, CA, CT) **Yes** **No**

If yes where and when _____

Have you or anyone in your household recently self-quarantined? **Yes** **No**

If yes please explain who and when _____

Have you experienced fever and symptoms of lower respiratory illness (e.g., cough and/or shortness of breath) in the last 14 days or any of the following? **Yes** **No**

Have you been in close contact with a person who is under investigation for **COVID-19** while that person was ill?
Yes **No**

Have you been in close contact with an ill laboratory-confirmed **COVID-19** patient? **Yes** **No**

Are you practicing Social Distancing? **Yes** **No**

If both exposure and illness are present:

1. Isolate employee (private room or separate area)
2. Place facemask on patient (simple surgical mask)
3. Wear appropriate PPE (medic N95, gloves, and any other required PPE)

Shore based status:

Temperature: _____ ° **Fahrenheit** **Celsius**

Are respiratory illness symptoms present? **Yes** **No**

Cough **Yes** **No** **If yes, is the cough: non-productive** **productive**

Fever **Yes** **No**

Shortness of Breath **Yes** **No**

FOR ANY YES ANSWERS, CONTACT MEDICAL CONTROL PHYSICIAN FOR FURTHER RECOMMENDATIONS

Date & time: _____

Shore based name and signature: _____