Avenue II COVID-19 Screening Form
PDF non-fillable version

Date:_____ **First and Last Name:**_____

IF YOU ARE CURRENTLY EXPERIENCING ANY OF THESE SYMPTOMS CALL 911: SEVERE DIFFICULTY BREATHING, SEVERE CHEST PAIN, FEELING CONFUSED OR UNSURE OF WHERE YOU ARE, LOSING CONSCIOUSNESS

Do you have any of these symptoms?
(choose any or all that are new, worsening and not related to other known causes or conditions)

Select "None of the above" if **both** of these apply:

- You do not have a fever **and**
- Your symptoms have been improving for at least 24 hours (48 hours if you had nausea, vomiting and/or diarrhea)

- ☐ Fever and/or chills
- ☐ Cough
- ☐ Shortness of breath
- ☐ Decrease or loss of taste or smell
- ☐ Muscle aches or joint pain
- ☐ Headache
- ☐ Nausea, vomiting and or diarrhea
- ☐ Abdominal pain
- ☐ Pink eye
- ☐ Runny or stuffy/congested nose
- ☐ Extreme tiredness *(general feeling of being unwell, lack of energy)*
- ☐ Sore throat *(painful swallowing or difficulty swallowing)*
- ☐ None of the above

IF YOU HAVE TWO OR MORE OF THE ABOVE SYMPTOMS DO NOT ATTEND WORK. CALL THE OFFICE OR ONCALL FOR DIRECTION.

☐ Have you been told that you should be quarantining, isolating or staying at home?
IF YES, DO NOT ATTEND WORK AND CALL THE OFFICE OR ONCALL FOR DIRECTION.

☐ Have you tested positive on a PCR or Rapid Antigen Test in the last 10 days?
IF YES, DO NOT ATTEND WORK AND CALL THE OFFICE OR ONCALL FOR DIRECTION.

☐ I attest the above to be true.

Signature: _____
type name or insert signature

Please email to covid@avenueii.com