



EMPLOYEE

COVID-19 Screening

SIGNS OR SYMPTOMS OF ILLNESS

Any Respiratory Symptoms:

Fever (T= _____ °F)

Cough

Shortness of Breath

New loss of taste or smell

*The presence of fever may be objective or subjective

OR at least TWO of these symptoms:

Headache

Runny Nose

Nasal Congestion

Chills

Muscle Pain

Sore Throat

Vomiting

Diarrhea

YES

NO

▶ **IF YES, employee should be COVID tested as soon as possible.**

▶ **Employee may work if well enough to work, afebrile, and testing negative for COVID.**

▶ **Employee should wear a well-fitting mask while symptoms persist.**

▶ **Employee should test again 24-48 hours after first test.**

▶ **Report COVID symptoms to Infection Control (860)234-4855.**

POSITIVE COVID TEST

Have you tested positive for COVID-19 in the last 10 days?

YES

NO

▶ **Employee is restricted from working for 7 days if they have a negative Rapid COVID test on day 5-7, or for 10 days if repeat rapid testing is not performed or if it is positive.**

▶ **Duration of work restriction may change after evaluation by Infection Control.**

▶ **Regardless of return to work date, employee should wear a well-fitting mask until after day 10.**

▶ **Report positive COVID tests to Infection Control (860)234-4855.**

COVID-19 EXPOSURE

In the last 10 days have you been in close physical contact with:

- Anyone who is known to have COVID-19?

OR

- Anyone who has any symptoms consistent with COVID-19?

YES

NO



- ▶ **Report all COVID Exposures to Infection Control (860)234-4855**
- ▶ **Employee may work if asymptomatic, they should wear a well-fitting mask while in the facility for 10 days after exposure.**
- ▶ **Employee should be COVID tested a minimum of three times: as soon as possible (but no sooner than 24 hours after exposure), if negative repeat test 48 hours from first test, if negative repeat 48 hours from second test.**
- ▶ **Employees that develop symptoms after a known COVID exposure should be COVID tested immediately**

EMPLOYEE NAME: _____ **DATE:** _____