

# COVID-19 Daily Self Checklist

## Employees

### Instructions:

- You are required to complete this checklist each day before reporting to work.
- If you answer YES to any of the questions below, STAY HOME and immediately contact your supervisor. You will not be permitted to return to work until you meet all return-to work criteria.
- If you answer NO to the questions below, you must turn this completed checklist in to your supervisor upon reporting to work.
- During your absences, you will have the choice to use sick leave under the Emergency Paid Sick Leave Act (“EPSLA”), limited to a maximum of two weeks (80 hours, or a part-time employee’s two-week equivalent) at full pay, or you may choose to use your District sick leave days. Please be aware the ESPLA sick leave expires on December 31, 2020. Please notify your supervisor of which sick leave you are electing.
- If you start feeling sick while at work or experiencing the symptoms listed below, report your symptoms to your supervisor immediately.

Question	Yes	No
Do you have a temperature of 100.4°F or greater?	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking fever-reducing medicines, such as those that contain aspirin, ibuprofen or acetaminophen, in order to reduce your fever?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had close contact or cared for someone with COVID-19 within the past 14 days?	<input type="checkbox"/>	<input type="checkbox"/>
Have you returned from travel outside the United States or on cruise ship or river boat within the past 14 days?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been directed to self-quarantine by a health care provider?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been directed to self-quarantine by the County or State Department of Public Health?	<input type="checkbox"/>	<input type="checkbox"/>
Are you experiencing any of the following symptoms?		
• Chills	<input type="checkbox"/>	<input type="checkbox"/>
• Cough	<input type="checkbox"/>	<input type="checkbox"/>
• Shortness of breath or difficulty breathing	<input type="checkbox"/>	<input type="checkbox"/>
• Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
• Muscle or body aches	<input type="checkbox"/>	<input type="checkbox"/>
• Headache	<input type="checkbox"/>	<input type="checkbox"/>
• New loss of taste or smell	<input type="checkbox"/>	<input type="checkbox"/>
• Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>
• Congestion or runny nose	<input type="checkbox"/>	<input type="checkbox"/>
• Nausea or vomiting	<input type="checkbox"/>	<input type="checkbox"/>
• Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>

I hereby acknowledge that I have received a copy of this COVID-19 Daily Self Checklist. I understand that I am required to honestly and accurately complete this checklist each day before reporting to work.

EMPLOYEE NAME: \_\_\_\_\_

DATE: \_\_\_\_\_