COVID-19 Home Health Screening **Mid-Michigan Library League**

Employee Name: _____

Date	In the past 24 hours have you experienced:									Have you had close contact in the last 14 days with an individual diagnosed with COVID-19?	Have you been directed or told by the local health department or your healthcare provider to self-isolate or self-quarantine?	PASS or FAIL	Initial
	Cough?	Chills?	Sore throat?	Body aches?	Loss of smell?	Loss of taste?	Shortness of breath?	Vomiting/ Diarrhea?	Fever greater than 100.4?				