Avenue II COVID-19 Screening Form

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 use the submit button or save and email to covidnotice@avenueii.com