

Daily Health Screening Tool

1. Do you have any of the following symptoms today or have you had any of them in the past 7 days?

| | | | |
|---|--|--|--|
| Fever $\geq 100.4^{\circ}\text{F}$ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sore throat | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Nasal and/or sinus congestion or pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Runny nose | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cough, productive or dry | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of breath | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Conjunctivitis/Pink eye | <input type="checkbox"/> Yes <input type="checkbox"/> No | Joint or muscle aches (not exercise related) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Altered or loss of taste or smell | <input type="checkbox"/> Yes <input type="checkbox"/> No | Vomiting, diarrhea, abdominal pain or nausea | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chills with or without shaking, or teeth chattering | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rash or discoloration of fingers/toes | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fatigue | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headache | <input type="checkbox"/> Yes <input type="checkbox"/> No |

2. What is your temperature? _____

3. At any time in the past 7 days, have you ...

- Been in close contact with anyone experiencing flu-like symptoms? Yes No
- Been in contact with a person with a presumed diagnosis of COVID-19? Yes No
- Been caring for or in close contact with a laboratory-confirmed case of COVID-19? Yes No
- Tested positive or had a presumed diagnosis of COVID-19 at any time AND did not notify or have not been cleared to return to work by Health Services? Yes No

If you answer **Yes to any symptoms/exposures OR you have a temperature $\geq 100.4^{\circ}\text{F}$, DO NOT come into the Library. Call your supervisor for further directions and seek medical advice.**

4. Contact HSD for guidance if you have visited a nursing home or traveled outside of DC, Maryland or Virginia in the past 7 days.

5. Email your supervisor and HSD. DO NOT email this questionnaire to the Library.

- At any point, if you answer YES to the questionnaire OR have a temperature $\geq 100.4^{\circ}\text{F}$: Send **one** email to your supervisor with a copy to HSDCOVID-check-in@loc.gov with your name in the subject line stating the following:

- I have answered YES to a question and/or I have a temperature greater than 100.4. I can be reached at [PHONE NUMBER] to answer questions related to my symptoms.

- If you are arriving at a Library facility not on Capitol Hill, outside of screening hours at any location, or for weekend building access on Capitol Hill, send **one** email to your supervisor with a copy to HSDCOVID-check-in@loc.gov with your name in the subject line stating one of the following statements based on your self-assessment:

- I have answered no to all questions and do not have a fever
- I have answered YES to a question and/or I have a temperature greater than 100.4. I can be reached at [PHONE NUMBER] to answer questions related to my symptoms.