# City of Elizabeth COVID-19 Employee Daily Symptom Check List

Review the following questions daily and **STAY HOME** if you answer "**YES**" to any of the following

| Check if **YES** | **Do you have any of the following Symptoms?** |
|---|---|
| ☐ | Fever of 100.4°F/38°C or Higher |
| ☐ | Cough |
| ☐ | Shortness of Breath or Difficulty Breathing |
| ☐ | Chills |
| ☐ | Unexplicable Fatigue |
| ☐ | Muscle Pain or Body Aches |
| ☐ | Headache |
| ☐ | New Loss of Taste or Smell |
| ☐ | Sore Throat |
| ☐ | Congestion or Runny nose |
| ☐ | Nausea or Vomiting |
| ☐ | Diarrhea |
| ☐ | Other signs of New Illness that are unrelated to a preexisting condition (such as seasonal allergies) |

| Check if **YES** | **Questions** |
|---|---|
| ☐ | Have you been in close contact with anyone with confirmed COVID-19? Close contact means being within 6 feet (2 meters) of an infected person for 15 minutes or more within a 24-hour period. |
| ☐ | Have you had a positive COVID-19 test for the active virus in the past 10 days? |
| ☐ | Within the past 14 days, has a public health or medical professional told you to self-monitor, self-isolate, or self-quarantine because of concerns about COVID-19? |
| ☐ | Have you/or someone you have had contact with travelled to any of the states on the CDC's restricted travel list? |

**If you answer "YES" to any of these questions, stay home and contact your supervisor.**