(Office Use Only)

Date:_____

MetroED
Metropolitan Education District

COVID-19 Screening

As the coronavirus (COVID-19) pandemic continues, we monitor the situation closely and follow all local authorities, health department, and state guidance to prevent the spread of the virus and reduce the potential risk of exposure.

We require everyone is assessed for COVID-19 symptoms and risk factors each time arriving at our facility. The information on this assessment is confidential. Regardless of your answers, if you feel sick, have symptoms related to COVID-19, do not come on our campus, stay home, and contact a healthcare professional immediately for further instructions.

By completing this assessment, I acknowledge I will follow ALL MetroED's District COVID-19 safety protocols and will:

- ✓ not come on campus while sick;
- ✓ have my temperature taken prior to entering the campus;
- ✓ wear a face covering (with the exception of eating or drinking, virtual teaching);
- ✓ practice social distancing (minimum 6 feet apart);
- ✓ wash or use hand sanitize upon arrival, before/after preparing food, after using the toilet, blowing my nose, touching garbage; and
- ✓ wash hands every two hours while on campus.

Please indicate your purpose for visiting our campus below (choose one) with an X:

- **Employee:** ☐
  - **SVCTE** ☐
  - **SVAE** ☐
  - **DO** ☐
  - **SO** ☐
  - **M & O** ☐
- **Student:** ☐
  - **SVCTE** ☐
  - **SVAE** ☐
- **Visitor:** ☐
  - **Testing** ☐
  - **Pickup/Dropoff** ☐
  - **Visiting** ☐ _____

Name (*print*): _____

Telephone Number (*required*): _____

Email (*optional*): _____

Comment(s): _____

1. Have you had a positive COVID-19 test in the past 14 days?

2. Do you live in the same household with, or have you had close contact with, someone who in the past 14 days has been in isolation/quarantine for COVID-19 or had a test confirming they have the virus? Close contact is less than 6 feet for 15 minutes or more.

3. Have you had any of these symptoms in the past 24 hours that you cannot attribute to another condition?
   - Fever (100.0) or chills
   - Cough
   - Shortness of breath or difficulty breathing
   - Fatigues
   - Muscle or body aches
   - Headache
   - Recent onset of loss of taste or smell
   - Sore throat
   - Congestion or runny nose
   - Nausea or vomiting
   - Diarrhea

Did you answer **YES TO ANY** of the above questions?

Yes ☐ or No ☐

Signature: _____

Date: _____

For Official Use Only:

Access to Campus:

✓ _____ **Approved** ✓ _____ **Denied**

✓ _____ **AM** ✓ _____ **PM**

Screener's Name: _____

If denied, contact the covidliaison@metroed.net or 408-723-4245