

COVID-19 Visitor & Employee Self-Screening Form

Note: Employees and Students are intended to answer these questions at home prior to attending campus. Generally a physical copy of this form is not required. It is primarily for reference to the required self-screening questions.

The safety of our employees, students and visitors, remains the college's primary concern. As the coronavirus (COVID-19) outbreak continues to evolve and spread globally, the company is monitoring the situation closely and will periodically update company guidance on current recommendations from the CDC and WHO.

To help prevent the spread of COVID-19 and reduce the potential risk of exposure to our employees and visitors, we are conducting a simple screening questionnaire. Your participation is important to help us take precautionary measures to protect you and everyone in the building.

Thank you for your assistance!

I am a:

LCCC Employee

Visitor

Contact Information (Visitor only)

Name:

Mobile Number:

Email Address:

Location:

Employee Details

Visitor Details

Id #:

Company Name:

Name of Host:

If you answer yes to any of the following, do not access campus. Contact your supervisor and contact a medical provider.

Do you currently have any of the following?

- | | | |
|----------------------------|----------------------------|--|
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Fever (100.4 Fahrenheit or higher) or feeling feverish? |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Chills? |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | A new or worsening cough not caused by another health condition? |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | New or worsening difficulty breathing not caused by another health condition? |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Sore throat? |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | New or worsening muscle aches not caused by another health condition? |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | New or worsening headache that is not normal for you and not caused by another health condition? |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | New loss of sense of taste or smell? |

In the last two weeks, have you had close contact (within 6 feet for at least 10 minutes) with anyone who has been diagnosed with COVID-19?

Y N

Is the information on this form true and correct to the best of your knowledge?

Yes

No