

RALEIGH COUNTY SCHOOLS COVID-19 EMPLOYEE SELF-CHECK LIST (Weekly Report)

Name: _____ School: _____

Have you been within 6 feet of a person with lab-confirmed COVID 19 for at least 5 minutes? Yes _____ No _____

Monday: Date _____ Temperature _____

In the last 24 hours, any of the following new symptoms?

Fever of 100°F (37.8°C) or above: Yes _____ No _____	Alternating chills/sweating: Yes _____ No _____
Trouble breathing, severe wheezing: Yes _____ No _____	Muscle aches: Yes _____ No _____
Sore throat: Yes _____ No _____	Loss of smell or taste: Yes _____ No _____
Nausea, vomiting, diarrhea: Yes _____ No _____	Headache: Yes _____ No _____

Tuesday: Date _____ Temperature _____

In the last 24 hours, any of the following new symptoms?

Fever of 100°F (37.8°C) or above: Yes _____ No _____	Alternating chills/sweating: Yes _____ No _____
Trouble breathing, severe wheezing: Yes _____ No _____	Muscle aches: Yes _____ No _____
Sore throat: Yes _____ No _____	Loss of smell or taste: Yes _____ No _____
Nausea, vomiting, diarrhea: Yes _____ No _____	Headache: Yes _____ No _____

Wednesday: Date _____ Temperature _____

In the last 24 hours, any of the following new symptoms?

Fever of 100°F (37.8°C) or above: Yes _____ No _____	Alternating chills/sweating: Yes _____ No _____
Trouble breathing, severe wheezing: Yes _____ No _____	Muscle aches: Yes _____ No _____
Sore throat: Yes _____ No _____	Loss of smell or taste: Yes _____ No _____
Nausea, vomiting, diarrhea: Yes _____ No _____	Headache: Yes _____ No _____

Thursday: Date _____ Temperature _____

In the last 24 hours, any of the following new symptoms?

Fever of 100°F (37.8°C) or above: Yes _____ No _____	Alternating chills/sweating: Yes _____ No _____
Trouble breathing, severe wheezing: Yes _____ No _____	Muscle aches: Yes _____ No _____
Sore throat: Yes _____ No _____	Loss of smell or taste: Yes _____ No _____
Nausea, vomiting, diarrhea: Yes _____ No _____	Headache: Yes _____ No _____

Friday: Date _____ Temperature _____

In the last 24 hours, any of the following new symptoms?

Fever of 100°F (37.8°C) or above: Yes _____ No _____	Alternating chills/sweating: Yes _____ No _____
Trouble breathing, severe wheezing: Yes _____ No _____	Muscle aches: Yes _____ No _____
Sore throat: Yes _____ No _____	Loss of smell or taste: Yes _____ No _____
Nausea, vomiting, diarrhea: Yes _____ No _____	Headache: Yes _____ No _____

Employee Signature: _____ Date: _____

School Nurse: _____