COVID Employee Health Reporting Form

Please complete the form with as much information as possible

* Required

Person Completing Form

Your answer

Last Name of Employee confirmed, suspected, or exposed to COVID-19 *

Your answer

First Name of Employee confirmed, suspected, or exposed to COVID-19 *

Your answer

Employee ID # *

Your answer

Department/Campus *

Your answer

Street Address *

Your answer

City *

Your answer

Zip *

Your answer

Employee Telephone # *

Your answer

If the EMPLOYEE symptomatic, answer questions 1-9. If reporting for exposure to COVID, answer questions 10-15.

1. Date of Onset of Symptoms for EMPLOYEE

Date

mm/dd/yyyy

2. List Symptoms Experienced by EMPLOYEE

Your answer

3. Date of EMPLOYEE'S COVID-19 Test (if applicable)

Date

mm/dd/yyyy

4. EMPLOYEE'S Testing Location (if applicable)

Your answer

5. EMPLOYEES test results

- ◯ Positive
- ◯ Negative

6. EMPLOYEE'S Health Care Provider Name and #

Your answer

7. While interacting with district staff/students, was the employee wearing a face covering at all times? *

- ○ Yes
- ○ No

8. If NO, please list names of district staff who employee interacted with for more than 15 continuous minutes within 6ft. of each other without a face covering:

Your answer

9. Additional Information

Your answer

9. Additional Information

Your answer

10. Did EMPLOYEE have close contact, within 6 feet for at least 15 minutes without wearing a mask, with person symptomatic or confirmed COVID.

- ○ Yes
- ○ No

11. Date of last close contact with person symptomatic or confirmed COVID.

Date

mm/dd/yyyy

12. Date of Onset of Symptoms for person you came in close contact with.

Date

mm/dd/yyyy

13. Date of COVID Test person you came in close contact with (if applicable)

Date

mm/dd/yyyy

14. Test results for person you came in close contact with (if applicable)

- ○ Positive
- ○ Negative

15. Additional Information about person you came in close contact with

Your answer

Submit

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