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COVID-19 Screening Form

STARCARE
SPECIALTY HEALTH SYSTEM

Name (please print): _____
Check one: Employee ☐ Visitor ☐ Vendor ☐
Date of Screening: _____
StarCare Employee Number (If applicable): _____
Name of Vendor (If applicable) _____

Temperature Reading: _____

1. Do you have any signs or symptoms of a respiratory infection, such as:
   - ☐ Fever greater than 100 or feel feverish/chills
   - ☐ Runny nose
   - ☐ New cough
   - ☐ New loss of taste/smell
   - ☐ Sore throat
   - ☐ Diarrhea or vomiting
   - ☐ New shortness of breath
   - ☐ Unexplained muscle (back/neck)
   - ☐ Headache
   - ☐ Sinus or chest Congestion

2. Have you been exposed to anyone who has been sick with any of the symptoms listed above within the last 14 days?
   ☐ Yes ☐ No

3. Within the last 14 days, have you had close contact with someone who tested positive for COVID-19?
   ☐ Yes ☐ No

4. Have you worked in a facility or location with recognized COVID-19 cases?
   ☐ Yes ☐ No

5. Have you been fully vaccinated against COVID-19?
   ☐ Yes ☐ No

6. Please use the hand sanitizer provided at this desk once you have completed this form.

Employees: If you checked YES to any of the questions above, please contact your supervisor (from the lobby or your car) and request guidance. You may NOT proceed past the lobby without supervisor approval.

Vendors: If you checked YES to any of the questions above, please contact the Director of Plant Operations at 806-543-6421 for further instructions. You many NOT proceed past the lobby without further approval.

Staff/Vendor/Visitor Signature: _____

Please deposit the form into the secure box located on the screening table, submit to staff on site, or follow instructions posted on site.

March 30, 2022