SUNY Purchase College: Daily COVID Screening Questionnaire

As you are aware, due to the COVID-19 pandemic, businesses and employers are required to put new measures in place to comply with regulations established by New York State. One such requirement is a **mandatory** daily health screening. To meet this requirement the college has developed this questionnaire. Employees also have the option to complete an electronic questionnaire which can be accessed on the Purchase College website (Faculty and Staff/Quick Links). (This link is only for access to the electronic questionnaire.)

Everyone needs to be a responsible community member and recognize the importance of complying with and completing the COVID Screening Questionnaire. It is your responsibility to complete this survey every day of your normal work schedule/obligation before you come to campus or within one hour of arriving on campus. Supervisors will be responsible to ensure their direct reports complete the screening daily.

No additional information will be shared and no health information will be recorded/stored

Employee Name (Clearly Print Full Name – First and Last)	
Office/Department	
Week of	

Screening Questions: Please review the below questions.

If you answer "Yes" to any questions, do not come to work or leave work immediately. Please notify your supervisor and the Department of Human Resources for guidance at 914-251-6086 or 5961. Also contact your primary health care provider, or your local Department of Health: NYS DOH (888) 364-3065, NJ DOH (800) 962-1253, Connecticut DOH (833) 250-7633, Westchester DOH (914-813-5000)

1. Do you have a temperature equal to or more than 100°F? **(Yes or No)**
2. Are you coming to or working on campus today? (**Yes or No)**
3. Have you experienced any of the following symptoms (not related to chronic, known conditions or seasonal allergies)? **(Yes or No)**
   Symptoms can include:
   - Fever or chills
   - Cough
   - New loss of taste or smell
   - Muscle or body aches
   - Shortness of breath or difficulty breathing
   - Fatigue
   - Headache
   - Sore throat
   - Congestion or runny nose
   - Nausea or vomiting
   - Diarrhea
4. Have you tested positive for COVID-19 through a diagnostic test within the past 10 days? **(Yes or No)**
5. Have you had close contact with confirmed or suspected COVID-19 cases within the past 10 days? **(Yes or No)**

If you answered "No" to "*ALL*" of the above questions (#s 1-5), you may proceed to your workplace. If your answer to any of these questions changes throughout the workday, you must contact your supervisor immediately to let them know and leave campus. The NYS Traveler Health Form can be downloaded from the following website: https://coronavirus.health.ny.gov/covid-19-travel-advisory#traveler-health-form

Please **check** to confirm you have a mask in your possession available for immediate use: ☐

Initialing below attests that you **are not** experiencing any of the symptoms as listed above.

	Date Completed (MM/DD/Year)	**Initials**
Date Completed and Employee Initials		

Submit completed form to your supervisor.

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