

# COVID-19 CHECKLIST for PARTICIPANTS

This form duplicates the information requested on SoCo COVID Check App which can be downloaded for free and is completely voluntary by you. If you download the App, you will fill this form out once, perform a quick daily check and show your wellness badge, or text your supervisor that you have used the app and been approved.

Your participation is important to help us take precautionary measures to protect you and your fellow employees, and others who are on site. You have indicated that you do not wish to install the app on your personal device. We request that you complete this screening before participating in a LandPaths program or coming on to one of our properties to comply with <https://socoemergency.org/amendment-no-3-to-health-order-no-c19-09/>. You will need to submit this form certifying your lack of exposure or symptoms and have appropriate facial covering before being allowed to participate or work on site. You may find additional local information at <https://socoemergency.org/>

Thank you for your time.

**You must contact your Primary Care Physician or call 911 if you have any of the following severe symptoms:**

- Trouble breathing
- Persistent pain or pressure in chest
- New confusion or inability to stay awake
- Blue lips or face.

This is not a complete list. If you think you are experience a medical emergency, call your Provider or 911 immediately.

I do not have these symptoms

**Please answer yes or no to the following:**

In the last 24 hours, have you been in contact with anyone confirmed to have COVID-19?

Are you experiencing any of these COVID-19 related symptoms?

**Please complete the following checklist:**

Any symptoms that I'm experiencing (other than a temperature above 100°) have been cleared by my primary care provider

Cough

Fever --Temperature above 100\*

Chills

Sore Throat

Feeling achy

Shortness of breath/difficulty breathing

Nausea or vomiting

Unusual or new headache in the last 24 hours

Diarrhea

Loss of Taste or Smell

Tingling or numbness

None of the above

Participant Name:

Signature:

\_\_\_\_\_  
\_\_\_\_\_

Date:

\_\_\_\_\_

Staff Name:

Signature or initials:

\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_