Wellness Check Affirmation

Please answer the questions below as we transition back to on-site work at the Santa Barbara County Education Office.

1. Using questions #3 - #6 below, I agree to conduct a daily self-assessment wellness check to determine if I am well and symptom-free prior to coming to work each day.

   ☐ Agree

2. I agree to notify my direct supervisor if I experience any of the symptoms of COVID-19 as identified by CDC, have been diagnosed with COVID-19, or have recently had close contact with a person diagnosed with COVID-19.

   ☐ Agree

Wellness Check

3. I have a fever or symptoms of a fever (temperature over 100.4 degrees F.).

   ☐ Yes ☐ No

4. I have a cough **not** due to chronic or known condition.

   ☐ Yes ☐ No

5. I am having shortness of breath or difficulty breathing.

   ☐ Yes ☐ No

6. I am experiencing chills, fatigue, muscle or body aches, headache, sore throat, congestion or runny nose, nausea or vomiting, diarrhea, or a new loss of taste or smell.

   ☐ Yes ☐ No

If you indicated YES to any of the questions 3-6, contact your health care provider, please stay home until cleared by a health care provider or you are symptom-free for at least 72 hours, notify your direct supervisor, and follow established leave procedures.

My signature below attests to my agreement to comply with the above protocol.

______________________________ ____________________

Signature Date