1. **Are you currently, or have you recently had, any of the following symptoms?**

*Fever* ☐ YES ☐ NO *New or Worsening Cough* ☐ YES ☐ NO

*Sore Throat* ☐ YES ☐ NO *Loss of Taste or Smell* ☐ YES ☐ NO

*Nausea or Vomiting* ☐ YES ☐ NO *Difficulty Breathing* ☐ YES ☐ NO

*Diarrhea* ☐ YES ☐ NO *Fatigue or Muscle Aches* ☐ YES ☐ NO

*Headache* ☐ YES ☐ NO *Congestion, Runny Nose, Sneezing* ☐ YES ☐ NO

 If **“*Yes*”** to any of the above,when did symptoms start:

1. **Within the last 14 days, have you been around an individual with confirmed, or suspected, COVID-19?**

*Lived with?* ☐ YES ☐ NO *Intimate with?* ☐ YES ☐ NO

*Cared for?* ☐ YES ☐ NO *Within 6 ft of for >14 minutes?* ☐ YES ☐ NO

*Carpooled with?* ☐ YES ☐ NO *Other?* ☐ YES ☐ NO

 If **“*Yes*”,** please describe:

1. **Within the last 10 days, have you attended any type of family, social or public gathering, with 15 people or more, and where PPE and/or social distancing was unable to be maintained?**

*Wedding/Funeral* ☐ YES ☐ NO *Holiday Celebration* ☐ YES ☐ NO

*Sporting Event* ☐ YES ☐ NO *Airport* ☐ YES ☐ NO

*Indoor Concert* ☐ YES ☐ NO *Public Transportation* ☐ YES ☐ NO

*Education or Training* ☐ YES ☐ NO *Other*? ☐ YES ☐ NO

If **“*Yes*”,** please describe:

1. **Have you ever had a positive COVID 19 test?** ☐ YES ☐ NO

If **“*Yes*”,** please describe: (Include Date, Type of Test & Return to Work Instructions):

1. **Have you had a COVID 19 vaccination?** ☐ YES ☐ NO

If **“*Yes*”,** Select brand: ☐ Pfizer Date 1st dose: \_\_\_\_\_\_\_ Date 2nd dose: \_\_\_\_\_\_\_ Date Booster: \_\_\_\_\_\_

☐ Moderna Date 1st dose: \_\_\_\_\_\_\_ Date 2nd dose: \_\_\_\_\_\_\_ Date Booster: \_\_\_\_\_\_

☐ Johnson & JohnsonDate 1st dose: \_\_\_\_\_\_\_ Date Booster: \_\_\_\_\_\_

☐ AstraZeneca Date 1st dose: \_\_\_\_\_\_\_ Date 2nd dose: \_\_\_\_\_\_\_ Date Booster: \_\_\_\_\_\_

☐ Sinopharm Date 1st dose: \_\_\_\_\_\_\_ Date 2nd dose: \_\_\_\_\_\_\_ Date Booster: \_\_\_\_\_\_

☐ Other: \_\_\_\_\_\_\_\_\_ Date 1st dose: \_\_\_\_\_\_\_ Date 2nd dose: \_\_\_\_\_\_\_ Date Booster: \_\_\_\_\_\_

 **Test** **results**: Molecular: ☐Detect/Positive☐Non-detect/Negative ☐Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTE:** *If detect/positive, ask whether the person has traveled or interacted with anyone that will be flying offshore to identify close contacts prior to going offshore. Notify HSE Representative.*

***As of today, and to the best of my knowledge, I verify that the above information is accurate****.*

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Administrator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Physician Notified: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**