SAMPLE SELF-MONITORING CHART

Please take your temperature once daily before drinking anything hot or cold and before taking any medications that reduce a fever (i.e. acetaminophen, ibuprofen, aspirin)..

Please pay attention to how your body is feeling and if you have symptoms, mark in the appropriate column in the table below. Call your healthcare provider and health department contact person if you develop **ANY symptoms.** Begin strict self-isolation at home and follow guidance from your healthcare provider and/or local health department.

**** Important: Call 911 if you feel very ill or have difficulty breathing ****

			Symptoms							
Day	**Date**	**Temp**	**Cough**	**Difficulty Breathing**	**Sore Throat**	**Body Aches Joint Pain**	**Fatigue**	**Abrupt Loss of Smell/Taste**	**Diarrhea, nausea or vomiting**
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									

BUSINESS RESOURCES

DESCHUTES COUNTY HEALTH SERVICES

COVID-19 TRAINING LOG

A Training Log is not required by the directive but is a good way to track that all employees understand COVID-19. COVID-19 related training may include:

1. A review of the facility plan;
2. The employee health policy

BUSINESS NAME: _____

	Employee Name	Date Training Completed	Training Type (Online, At Facility, etc.)	Employee Signature
1				
2				
3				
4				
5				
6				
7				
8				

ALL EMPLOYEES HAVE BEEN TRAINED IN ACCORDANCE WITH THE POLICY WRITTEN FOR THIS

_____ _____

PERSON IN CHARGE SIGNATURE DATE

EMPLOYEE HEALTH AGREEMENT FOR COVID-19

Background

COVID-19 is a highly contagious viral illness that easily spreads through contact with others. Excluding sick employees from the workplace is one of the best defenses against community spread. This document is not a replacement for employee health and hygiene requirements in the Retail Food Law. Facilities are still required to restrict and exclude employees with symptoms of food-borne illnesses. Please consult the Food Code or your local health department for more information on those requirements, if needed.

This document is not a substitute for medical advice. If you have concerns about your health and COVID-19, please consult a medical provider. Indicator symptoms of COVID-19 may change as new information is discovered.

Agreement

I AGREE TO NOT WORK IF I HAVE, OR RECENTLY HAD:

1. A new dry cough
2. A newly identified shortness of breath or difficulty breathing

   OR

   Two or more of the following symptoms:

1. Fever (above 100.4 °F)
2. Chills
3. Repeated shaking with chills
4. Muscle pain
5. Headache
6. Sore throat
7. New loss of taste or smell

I UNDERSTAND THAT OTHER SYMPTOMS MAY BE ASSOCIATED WITH COVID-19 AND SHOULD BE CONSIDERED WHEN DETERMINING WHETHER TO WORK.

I UNDERSTAND THAT A DAILY SYMPTOM CHECK WILL BE REQUIRED BEFORE I BEGIN WORKING EACH SHIFT.

Employee Name	Employee Signature	Date
Person In Charge Name	**Person In Charge Signature**	**Date**

BUSINESS RESOURCES

DESCHUTES COUNTY HEALTH SERVICES