



QUARANTINE LEAVE REQUEST CHECKLIST AND CONSENT FORM	
Date/Time:	
Employee Name (Last, First)	

*\* The Quarantine Leave for Peace Officers and Detention Officers Request Form must accompany this checklist. Please email both forms to the Jefferson County Public Health Authority at: [eede@co.jefferson.tx.us](mailto:eede@co.jefferson.tx.us).*

**Manual Self-Triage Survey**

*\*Please note, the questions asked are used solely for the purpose of ensuring employees return to the workplace safely and at the appropriate time and NOT for medical diagnoses or treatment. If you have any symptoms and/or other medical concerns, please visit your healthcare provider.\**

**Demographic Information**

Name (Last, First):	
DOB:	
Sex:	
Phone:	
Email:	
Position:	
Department:	
Supervisor Name:	

**Medical Data**

Temperature:	
Heart Rate (if available):	

**Exposure History**

Have you been exposed to an individual who tested positive for COVID-19 within the last 14 days or had symptoms of COVID-19 in the past 48 hours? (Exposure is defined as being within 6 feet for a total of 15 minutes or more.)	
Is this a household exposure (someone that lives in your home)?	

**Testing History**

Have you been tested for COVID-19 in the last 30 days? If yes, what were the results? (Positive, Negative, Inconclusive, Pending)	
What date was your COVID-19 test performed?	

**Vaccine History**

Have you received the COVID-19 vaccine?	
If Yes, please attach a copy of your vaccination card. (or include details on manufacturer and date)	



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**Travel**

Have you traveled outside Jefferson County in the last 30 days? (yes/no)

Where did you travel?

How long did you visit this location? (number of days)

When did you return?

**Risk Assessment**

*Please indicate if you have any of the risk factors below:*

- Lung Disease (asthma, emphysema/COPD)
- Hypertension (high blood pressure)
- History of Diabetes
- History of Cardiovascular disease
- Immunocompromised Condition
- Current smoker, including vaping
- If female, pregnant or less than 2 weeks postpartum
- History of Cancer
- Other
- None of the above

**History of Present Illness**

*Have you recently developed any new or abnormal symptoms? (yes/no)*

**Symptoms:**

Fever

Chills

Fatigue

Muscle Pain/Body Aches

Headache

New Loss of Taste/Smell

Sore Throat

Congestion/Runny Nose

Cough

Difficulty Breathing (Shortness of Breath)

Nausea/Vomiting

Diarrhea

Other Symptoms

What was the date when your symptoms first appeared? (Approximately)

Have you recently had a fever? (yes/no) Highest temperature recorded?



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## QUARANTINE LEAVE REQUEST PARTICIPATION CONSENT FORM

Name: \_\_\_\_\_ Telephone (work): \_\_\_\_\_

Email: \_\_\_\_\_ Telephone (mobile): \_\_\_\_\_

Department: \_\_\_\_\_

I am voluntarily submitting information requested by Jefferson County Health Authority in aid of evaluating whether to approve my Quarantine Leave Request and I confirm the following:

I have read the Jefferson County Quarantine Leave Policy for Peace Officers and Detention Officers (attached).

I am voluntarily providing and submitting to Jefferson County Health Authority information on the Quarantine Leave Request Checklist including proof of vaccination.

I understand a copy of this form will be maintained by Jefferson County Public Health for the applicable retention period.

I understand that the Jefferson County Quarantine Leave Policy may be modified at any time.

I understand this voluntary consent remains in effect until revoked by me in writing.

I understand I have the right to revoke this consent and withdraw my Quarantine Leave Request by notifying Jefferson County Health Authority at [eede@co.jefferson.tx.us](mailto:eede@co.jefferson.tx.us) and Human Resources at [hrdept@co.jefferson.tx.us](mailto:hrdept@co.jefferson.tx.us).

I understand that withdrawal of my Quarantine Leave Request will preclude entitlement to the benefit(s) of the Jefferson County Quarantine Leave Policy.

I understand there is a potential my Quarantine Leave Request Checklist information may be re-disclosed by the recipient in which case confidentiality of this information will no longer be protected.

I acknowledge receipt of a copy of this signed consent form.

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