

EMPLOYER DAILY COVID-19 SCREENING FORM

1. Are you currently or in the past 24 hours suffering from any of the following symptoms –

Fever Yes No

Cough Yes No

Shortness of breath Yes No

Sore throat Yes No

New loss of smell or taste Yes No

Gastrointestinal problems, including nausea, diarrhea, and vomiting?

Yes No

2. Have you lived with, or had close contact with, someone in the last 14 days diagnosed with or displaying the symptoms of COVID-19?

Yes No

3. Have you travelled via airplane internationally or domestically in the last 14 days?

Yes No

Date: _____, 2020

Signature

Printed Name

Employer Notes: (Do not identify anyone other than the employee due to HIPAA):

If applicable/available: Temperature: _____ send home if over 100.4°

Other:

Date: _____, 2020

Signature