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 100.4º

Other:

Date: _____, 2020 _____
Signature