COVID-19 Daily Health Screening

INSTRUCTIONS: Before leaving your home to travel to an office or worksite, please complete the following daily health screening form.
*Required

*Name: _____

*Date: _____

*Office or worksite: _____

*Estimated time of arrival to work location: _____

*Are you experiencing any of the following symptoms: felt feverish, had a temperature of 100.4°F or higher, cough, shortness of breath, sore throat, vomiting/diarrhea, new loss of taste or smell, muscle pain, or headache?

☐ Yes ☐ No Current temperature: _____

*Have you had close contact with an individual diagnosed with COVID-19 in the last 14 days?

☐ Yes ☐ No

*Have you engaged in any activity or travel within the last 14 days that puts you at higher risk to contract COVID-19, such as being around large groups of people without engaging in social distancing measures and wearing a face covering?

☐ Yes ☐ No

*Have you been directed or told by the local health department or your healthcare provider to self-isolate or self-quarantine?

☐ Yes ☐ No

*Did you answer YES to Questions 5, 6, 7 or 8?

☐ I answered YES to *one or more* of the screening questions or reported a temperature of 100.4°F or higher. I am not able to report to the office and I will contact my supervisor.

☐ I DID NOT answer yes to any of the screening questions. I am approved to report to the office or worksite.

Coronavirus Disease (COVID-19) Workplace Health Screening

Company Name: _____

Employee Name: _____ Date: _____ Time In: _____

In the past 24 hours, have you experienced:

Subjective fever (felt feverish):	☐ Yes	☐ No	New loss of taste or smell:	☐ Yes	☐ No
New or worsening cough:	☐ Yes	☐ No	Muscle pain:	☐ Yes	☐ No
Shortness of breath:	☐ Yes	☐ No	Headache:	☐ Yes	☐ No
Sore throat:	☐ Yes	☐ No			
Vomiting/Diarrhea:	☐ Yes	☐ No			

Current temperature: _____

If you answer "yes" to any of the symptoms listed above, or your temperature is 100.4°F or higher, please do not go into work. Self- isolate at home and contact your primary care physician's office for direction.

- You should isolate at home for minimum of 10 days since symptoms first appear.
- You must also have 3 days without fevers and improvement in respiratory symptoms

Have you had close contact in the last 14 days with an individual diagnosed with COVID-19?	☐ Yes	☐ No
Have you engaged in any activity or travel within the last 14 days that puts you at higher risk to contract COVID-19, such as being around large groups of people without engaging in social distancing measures and wearing a face covering?	☐ Yes	☐ No
Have you been directed or told by the local health department or your healthcare provider to self-isolate or self-quarantine?	☐ Yes	☐ No

If you answer "yes" to any of the above questions, please do not go into work. Self- isolate at home and contact your primary care physician's office for direction.