COVID 19 SCREENING FORM

Employee NAME:

DATE:

TIME:

HAVE YOU RECENTLY OR ARE YOU EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS:

A fever (100.4°F or higher) or the sense of having a fever?	☐ **YES**	☐ **NO**
Cough not attributed to another health condition?	☐ **YES**	☐ **NO**
Shortness of breath not attributed to another health condition?	☐ **YES**	☐ **NO**
Sore throat not attributed to another health condition?	☐ **YES**	☐ **NO**
Muscle aches not attributed to another health condition or a specific activity (such as physical exercise)?	☐ **YES**	☐ **NO**
A loss of taste or smell not attributed to another health condition?	☐ **YES**	☐ **NO**

SIGNED: