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 or worsening cough: ☐ Yes ☐ No

New loss of taste or smell: ☐ Yes ☐ No

Shortness of breath: ☐ Yes ☐ No

Muscle pain: ☐ Yes ☐ No

Sore throat: ☐ Yes ☐ No

Headache: ☐ 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.