Daily COVID-19 Health Screening

Please review this form each day prior to starting your shift.
Read each question carefully and examine the answer that applies to you.

Have you experienced any of the following symptoms in the past 48 hours:

- Fever or chills (Temperature of 100.4 or higher)
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

Within the past 14 days, have you been in close physical contact (6 feet or closer for at least 15 minutes) with a person who is known to have laboratory-confirmed COVID-19 or with anyone who has any symptoms consistent with COVID-19?

Are you isolating or quarantining because you may have been exposed to a person with COVID-19 or are worried that you may be sick with COVID-19?

Are you currently waiting on the results of a COVID-19 test?

Did you answer NO to ALL QUESTIONS?

- ✓ **You are APPROVED to start your work shift.**

Did you answer Yes to ANY QUESTION?

- **Please STAY HOME.**