**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