Employee Daily COVID-19 Health Screening Questionnaire

Please answer the following questions:

1. Have you come into close contact (within 6 feet) with someone who has tested positive for or shown symptoms of COVID–19 in the past 14 days?

   Yes No

2. Have you had a fever (greater than 100.4 F or 38.0 C) OR symptoms of lower respiratory illness such as cough, shortness of breath, or difficulty breathing in the past 14 days?

   Yes No

3. Are you currently experiencing a fever (greater than 100.4 F or 38.0 C) OR symptoms of lower respiratory illness such as cough, shortness of breath, or difficulty breathing?

   Yes No

4. Have you tested positive for COVID-19 in the past 14 days?

   Yes No

Name: ____

Date: ____