COVID-19 ON-SITE HEALTH SCREENING

I am a: ☐ Employee ☐ Visitor

Name _____

Mobile Number _____

Email _____

Department _____

Visitor's Company Name _____

Name of Company Host _____

*If the answer is **yes** to one or more of the following questions, individuals should report to Isolation Coordinator or Human Resources.*

All Employees and Visitors:

Are you showing any signs of one or more of the following symptoms?

Temperature over 100.4 ºF, cough, shortness of breath, difficulty breathing, tiredness, chills, repeated shaking with chills, muscle pain, headache, sore throat, or new loss of taste or smell within the last 3 days?

Yes ☐ No ☐ If temperature, what was the reading? _____

Additional Questions for Visitors:

Within the last 14 days, have you been tested for COVID-19 or has a medical professional advised you that you should be tested?

Yes ☐ No ☐

Have you had contact with anyone showing symptoms and diagnosed with coronavirus within the last 14 days?

Yes ☐ No ☐

Is the information you provided on this form true and correct to the best of your knowledge?

Yes ☐ No ☐

Prepared by

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