COVID-19 Daily Employee Symptom Screening Survey:

Have you had a fever in the past 48 hours (>100 Degrees Fahrenheit - Orally)?

☐ Yes ☐ No ☐ Unsure

Current temperature (Fahrenheit): ________________

Have you had any of the following new symptoms?

Chills?	☐ Yes | ☐ No
Cough?	☐ Yes | ☐ No
Shortness of breath or difficulty breathing?	☐ Yes | ☐ No
Sore throat?	☐ Yes | ☐ No
Muscle aches?	☐ Yes | ☐ No
Vomiting or diarrhea?	☐ Yes | ☐ No
New loss of taste or smell?	☐ Yes | ☐ No

Has anyone in your household been diagnosed with, or tested positive for COVID in the last 14 days?

☐ Yes | ☐ No

Date form completed: ________________________

Completed by: ____