COVID-19 SYMPTOM CHECK FOR EMPLOYEES

BUSINESS NAME: **DATE:**

	Employee Name	New Dry Cough?	New Shortness of Breath Or Difficulty Breathing?	Any Other Symptoms of Concern? ** **IF THE EMPLOYEE HAS TWO OR MORE OF THESE SYMPTOMS, THEY SHOULD NOT WORK**	Person In Charge Signature	Able to Work? (Yes/No)
1						
2						
3						
4						
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12						

WERE ALL EMPLOYEES SCREENED TODAY? YES NO

PERSON IN CHARGE SIGNATURE

**Other Symptoms of Concern Include: Fever (above 100.4° F), Chills, Repeated Shaking with Chills, Muscle Pain, Headache, Sore Throat, New Loss of Taste or Smell

IF THE EMPLOYEE HAS TWO OR MORE OF THESE SYMPTOMS, THEY SHOULD NOT WORK