ATTACHMENT A

COVID-19 EMPLOYEE DAILY SCREENING FORM

Employee Name: _____

Two-week period: _____

Each employee must answer the following questions each morning prior to coming into the office:

1. Have you been in close contact or staying in the same household as someone with a known or suspected case of corona-virus (COVID-19)?

   to 14 days.) YES ☐ NO ☐

2. Are you ill today? YES ☐ NO ☐

3. Do you have any of the following symptoms? YES ☐ NO ☐
   - Fever of 100.4 or higher or chills
   - Cough
   - Shortness of breath or difficulty breathing
   - Fatigue
   - Muscle or body aches
   - Headache
   - New loss of taste or smell
   - Sore throat
   - Congestion or runny nose
   - Nausea or vomiting
   - Diarrhea

4. Have you been in prolonged close contact or staying in the same household as someone with any of the above symptoms? YES ☐ NO ☐

1.	Date: _____	Symptoms:	☐ No	☐ Yes:	_____	Initials:
2.	Date: _____	Symptoms:	☐ No	☐ Yes:	_____	Initials:
3.	Date: _____	Symptoms:	☐ No	☐ Yes:	_____	Initials:
4.	Date: _____	Symptoms:	☐ No	☐ Yes:	_____	Initials:
5.	Date: _____	Symptoms:	☐ No	☐ Yes:	_____	Initials:
6.	Date: _____	Symptoms:	☐ No	☐ Yes:	_____	Initials:
7.	Date: _____	Symptoms:	☐ No	☐ Yes:	_____	Initials:
8.	Date: _____	Symptoms:	☐ No	☐ Yes:	_____	Initials:
9.	Date: _____	Symptoms:	☐ No	☐ Yes:	_____	Initials:
10.	Date: _____	Symptoms:	☐ No	☐ Yes:	_____	Initials: