



Employee Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

In the past 24 hours, have you experienced the following:

	YES	NO
Fever	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>
Sneezing	<input type="checkbox"/>	<input type="checkbox"/>
Aches/Pains	<input type="checkbox"/>	<input type="checkbox"/>
Runny/Stuffy Nose	<input type="checkbox"/>	<input type="checkbox"/>
Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
Have you recently been in close contact with anyone who has exhibited any symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
Have you recently been in contact with anyone who has tested positive for COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>
Have you recently traveled to a restricted area that is under a Level 2, 3 or 4 Travel Advisory according to the U.S. State Department? Including China, Italy, Iran, and most countries in Europe?	<input type="checkbox"/>	<input type="checkbox"/>

What is your temperature today? \_\_\_\_\_