Daily Employee Checklist

1. Date *

Example: January 7, 2019

2. Staff member Name *

3. Have you had an COVID-19 symptoms in the last 14 day? People with these symptoms may have COVID-19: Cough, shortness of breath or difficulty breathing, fever, chills, muscle pain, sore throat, new loss of taste or smell. *

Mark only one oval.

☐ Yes
☐ No

4. Have you had a positive COVID-19 test in the past 14 days? *

Mark only one oval.

☐ Yes
☐ No

5. Have you had close contact with a confirmed or suspected COVID-19 case in the past 14 days? *

Mark only one oval.

☐ Yes
☐ No

6. Temperature today *

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