DAILY COVID 19 SCREENING REPORT

Site Location/Name_____

Day/Date_____/_____

QUESTIONS (to be completed daily and initialed by each essential named employee working)

1. Have you traveled to an area with known local or out of state spread of COVID-19 in the past 14 days?

2. Have you, or anyone in your residence, come into close contact (within 6 feet) with someone who has suspected or confirmed COVID -19 diagnosis in the past 14 days either at home or on a jobsite?

3. Have you had a fever (greater than 100.4 F or 38.0 C) OR symptoms of lower respiratory illness such as cough, shortness of breath, or difficulty breathing in the past 14 days?

4. Are you currently experiencing a fever (greater than 104.4 F or 38.0 C) OR symptoms of lower respiratory illness such as cough, shortness of breath, or difficulty breathing?

Note: If employee answers "Yes" to any of the above questions, they fail and that employee is to leave the workplace/jobsite immediately and seek medical evaluation.

Employee	Question 1	Question 2	Question 3	Question 4	**P**ass or **F**ail