Health Screening Questionnaire

Date:_____

Name:_____

Department:_____

This form shall be completed prior to entering work. Please review the questions as a daily reminder and if you have answered YES to any of these questions, please do not report to work. Notify your Supervisor and HR immediately. If you are unable to complete this form prior to coming to work, please complete it as soon as you are at work.

The answers to these questions will be read by Human Resources and should be submitted to HR upon completion.

		YES	NO
1.	I or a household family member has one or more symptoms causing me/them to feel unwell. Symptoms may include, but are not limited to, fever 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, and diarrhea.	❑	❑
2.	I have traveled internationally or to any destination via cruise ship in the last 10 days.	❑	❑
3.	I have had contact with an individual who has tested positive for COVID-19 within the last 10 calendar days.	❑	❑
4.	I have taken my temperature today, and it is higher than 100.4 F	❑	❑

Please Return completed forms to Human Resources