Company Name

Health Screening Log

Screener Name:_____Date:_____

Questions:

1. **Have you experienced any COVID-19 symptoms in the past 14 days? (cough, shortness of breath, fever above 100.4, chills, muscle pain, sore throat, lost of taste or smell)**
2. **Have you tested positive for COVID-19 in the past 14 days?**
3. **Have you come in close contact with a confirmed or suspected COVID-19 case in the past 14 days?**

	Name	Contact Number	Answered all Questions No	Answered any Question Yes	Permitted to Enter (Y or N)
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

ANY INFORMATION OBTAINED DURING THE SCREENING PROCESS WILL BE HANDLED WITH ABSOLUTE CONFIDENTIALITY AND WILL ONLY BE USED TO ALLOW OR DISALLOW EMPLOYEES FROM ENTRY INTO THE WORKPLACE.