COVID-19 DAILY EMPLOYEE SCREENING

Employee Name: _____

Facility: _____ Date: _____

Do you currently have any of the following?

Symptom	Yes	No	Date of Onset
Chills			
Cough – excluding chronic cough due to a known medical reason other than COVID -19			
Fever of 100.4 or higher Today's temperature: _____			
Muscle Pain			
New loss of taste or smell			
Shortness of Breath or difficulty breathing			
Sore Throat			

Have you had any close contact in the last 14 days with someone with a diagnosis of COVID-19? Yes___ No___

If yes, what was the date? _____

Have you travelled internationally or outside of Michigan within the past 14 days (excluding commuting from a home location outside of Michigan? Yes___No___

If yes, what was the date? _____

Employee Signature: _____

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