COVID-19 DAILY EMPLOYEE SCREENING

Employee Name: _____

Facility: _____ Date: _____

Do you currently have any of the following?

Symptom	Yes	No	Date of Onset
Fever of 100.4 or higher Today's Temperature: _____			
Cough – excluding chronic cough due to a known medical reason other than COVID -19			
Shortness of Breath			
At least 2 of the following symptoms (circle any that apply): • Chills • Repeated shaking with chills • Muscle Pain • Sore Throat • New loss of taste or smell • Diarrhea – excluding diarrhea due to known medical reasons • Extreme Fatigue			

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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