Name (Print):		**Name (Signed):**	

Date:		***Location:***		***Manager:***	

In the past 24 hours, have you experienced any of the following:

1. Fever – List Temperature: ____________
   - ☐ Yes
   - ☐ No
2. Runny or Stuffy Nose
   - ☐ Yes
   - ☐ No
3. Fatigue
   - ☐ Yes
   - ☐ No
4. Sore Throat
   - ☐ Yes
   - ☐ No
5. Cough
   - ☐ Yes
   - ☐ No
6. Diarrhea
   - ☐ Yes
   - ☐ No
7. Sneezing
   - ☐ Yes
   - ☐ No
8. Headache
   - ☐ Yes
   - ☐ No
9. Aches and Pains
   - ☐ Yes
   - ☐ No
10. Shortness of breath
    - ☐ Yes
    - ☐ No
11. Have you recently been in close contact with anyone who has exhibited any symptoms or quarantined?
    - ☐ Yes – Please provide details: ____
      ____
    - ☐ No
12. Have you recently been in contact with anyone who has tested positive for COVID-19?
    - ☐ Yes – Please provide details: ____
      ____
    - ☐ No
13. Have you recently traveled to a restricted area that is under a Level 2, 3, or 4 Travel Advisory according to the U.S. State Department? Including: China, Italy, Iran, and most countries in Europe.
    - ☐ Yes
    - ☐ No