

COVID-19 Employee Daily Self-Health Assessment



*This form is for personal use by employees. It is not intended to be submitted to supervisor.

In the past 24 hours, have you experienced:

Fever (felt feverish or above 100.4° F)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
New or worsening cough:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Shortness of breath:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Loss of Taste or Smell:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chills:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other CDC Recognized COVID-19 Symptoms:	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If you answer “yes” to any of the questions listed above, or your temperature is 100.4° F or higher, do not go into work and contact your supervisor.

In the past 48 hours, have you:

Had close contact as defined by the CDC with an individual diagnosed with COVID-19?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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If you answer “yes”, do not go into work and contact your supervisor.