EMPLOYEE SCREENING FORM

NAME

DATE:														
TEMPERATURE:														
In the last 24 hours or since your last shift have you experienced any new:	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
COUGH														
SHORTNESS OF BREATH														
FEVER														
CHILLS														
HEADACHE														
MUSCLE PAIN														
SORE THROAT														
LOSS OF SMELL OR TASTE														

NAME

DATE:														
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In the last 24 hours or since your last shift have you experienced any new:	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
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