Daily Health Screening at Entry

Name_____ Date_____

Temperature_____

(must be under 100.4)

Was medication used to lower temperature? _____

Have you been in close contact (within 6 feet) with anyone diagnosed with COVID-19 in the past 14 days? _____

Does anyone in your household have symptoms of illness? (fever, cough or shortness of breath) _____

By signing below, I attest that all the above questions have been answered honestly.

Signature Telephone Number