

Sample COVID-19 SELF-SCREENING FORM



Symptom checker for employees, visitors and contractors

Name:

Date:

Visitor Employee Contractor

Job Title:

Worksite:

Address:

DETAILS OF REPORTER

Name:

Job title:

Telephone Number:

Do you/they have any of the following symptoms:

- Cough
- Shortness of breath, difficulty breathing

Or at least two of these symptoms:

- Fever >37.77°C (100°F) or higher
- Chills
- Repeated Shaking with chills
- Muscle Pain
- Headache
- Sore throat
- New loss of taste or smell

If any of the above symptoms are present, continue with rest of form.

Coronavirus preparation and arrangements to be made for employees who become ill at work

Time of fever on-set:

Time of isolation:

Symptoms and isolation periods will be updated periodically as information becomes available following the emergence of a pandemic virus strain.

Location of Isolation:

Where referred to:

Notes: