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SELF-REPORT HEALTH SCREENING

Name:__________________________ Date: ______________________________

Email: __________________________ Cell Number: __________________________

Client/Company: ____

Temperature (measured today): __________

Please answer the following questions:

Question	Answer
1) Have you had a fever of over 100.4 in the last 14-days?	YES / NO
2) Have you had any difficulty breathing in the last 14-days?	YES / NO
3) Have you had any of the other following symptoms in the last seven days?	
a. Cough	YES / NO
b. Shortness of Breath or Difficulty Breathing	YES / NO
c. Chills	YES / NO
d. Muscle Pain	YES / NO
e. Sore Throat	YES / NO
f. Nausea, Vomiting, or Diarrhea	YES / NO
4) Have you been in contact with a confirmed COVID-19 positive person (family member or otherwise) in the last 14-days?	YES / NO

By signing below, I acknowledge that the above statements are true and correct to the best of my ability, and I certify to their accuracy.

Signature: ________________________________