Construction Site Daily COVID-19 Health Screening Form

Date

Employee Name

Employee ID / Badge #

Company / Contractor Name

1. Do you have any of the following symptoms? (Fever, cough, shortness of breath, sore throat, loss of taste/smell, etc.)

- Yes
- No

2. Have you been in close contact with anyone diagnosed with COVID-19 in the past 14 days?

- Yes
- No

3. Have you been instructed to self-isolate or quarantine by a health official?

- Yes
- No

4. Temperature Check (if required):

Additional Comments

Employee Signature