Event Concession Stand Worker Wellness Form

Full Name

Date

Shift

Wellness Check

Temperature (Â°F)

Do you have any of the following symptoms? (Check all that apply)

Fever

Cough

Shortness of breath

Sore throat

None of the above

Other symptoms or wellness concerns

Recent Exposure

Have you been in close contact with a confirmed COVID-19 case in the past 14 days?

Comments

Signature