School Cafeteria Food Handler Screening Form

Full Name

Job Position

Date

School Name

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1. Are you currently experiencing any of the following symptoms?

- [ ] Fever
- [ ] Cough
- [ ] Vomiting
- [ ] Diarrhea
- [ ] Sore Throat

Other symptoms:

2. Have you been diagnosed with any communicable disease in the past month?

- ○ Yes
- ○ No

If yes, please specify

3. In the past 48 hours, have you had contact with anyone with confirmed or suspected communicable diseases?

- ○ Yes
- ○ No

If yes, please provide details

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4. Attestation

I affirm the above information is accurate to the best of my knowledge.

Signature

Date