

Senior Living Facility Food Server Health Form

Personal Information

Full Name

Date of Birth

Position

Facility Name

Health Screening

Have you had a fever in the last 14 days?

Do you currently have any of the following symptoms? (cough, sore throat, nausea, vomiting, diarrhea, etc.)

Have you been diagnosed with any infectious illness in the past month?

Have you been in close contact with anyone who has had a communicable disease in the past month?

Medical History

Allergies

Current Medications

Work Restrictions

Signature

Signature

Date