COVID-19 Workplace Entry Self-Assessment Sheet

Full Name

Date

1. Do you have any of the following symptoms?

- Fever or chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Loss of taste or smell
- Sore throat
- Headache
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

Yes No

2. Have you had close contact with anyone confirmed or suspected to have COVID-19 in the last 14 days?

Yes No

3. Have you tested positive for COVID-19 in the last 14 days?

Yes No

4. Have you been asked to self-isolate or quarantine by a health authority?

Yes No

Signature