ESC
EMPLOYER SERVICES

COVID-19 Employee Daily Health-Screening Form

Employee name: _____ Job title: _____

Supervisor's name: _____ Location: _____

OVER THE PAST 14 DAYS, HAVE YOU EXPERIENCED ANY OF THE FOLLOWING:

Date	COVID-19 Symptoms: Temp over 100.4, Respiratory Issues, Chills, Loss of Taste or Smell, Muscle Aches Yes or No	Positive COVID-19 Test Yes or No	Close Contact with Confirmed or Suspected COVID-19 Case Yes or No

I attest all the information above is true.

Signature: _____ Date: _____