

Health Questionnaire

Please respond to each of the following questions truthfully and to the best of your ability. Your participation is important to help us take precautionary measures to protect you and everyone else safe.

Name: _____

Phone Number: _____

Have you traveled in the last 2 weeks? If so, please list where:

In the last 48 hours, have you had any of the following symptoms?

Symptoms	YES	NO
Fever (chills, sweating)		
Shortness of Breath (not severe)		
Cough		
Muscle Pain		
Headache		
Sore Throat		
New Loss of Taste or Smell		
Vomiting or Diarrhea		

Any other symptoms you would like to share? _____

In the past 14 days, have you been in close proximity to anyone who was experiencing any of the above symptoms or have had contact with someone diagnosed with COVID-19? _____

Have you been tested for COVID-19 and are waiting to receive test results? _____

*Note

The information collected on this form will be used to determine only whether you may be infected with COVID-19. The information on this form will be maintained as confidential. Any questions should be directed to your manager or your human resources representative.

*Certification

I hereby certify that the responses provided above are true and accurate to the best of my knowledge. I also certify that I will inform production immediately if any of the above information changes for the duration of the production.

Print Name: _____ Date: _____

Signature: _____ Temperature: _____