FLUIX

Employee Covid-19 Screening Checklist

First Name

Last Name

Email

Phone number

What is your current temperature? ☐ °F ○ °C ○

Are you experiencing any of the following symptoms?

Symptom	Yes	No
Cough	○	○
Fever	○	○
Shortness of breath	○	○
Persistent pain or pressure in the chest	○	○
Loss of smell or taste	○	○
Chills	○	○
Muscle aches	○	○
Sore throat	○	○
Headache	○	○

Any other symptoms?

Have you had close contact in the last 14 days with an individual diagnosed with COVID-19? Yes ◯ No ◯

Have you traveled internationally or domestically in the last 14 days? Yes ◯ No ◯

If you reply YES to any of the questions above, or start feeling sick during your shift, inform your supervisor immediately.

Signature

Date