CONFIDENTIAL
COVID-19 Daily Health Screen

Employee Name:_____

Date of Health Screen:_____

PURPOSE: Each day, upon arrival to the restaurant and before entering, employees are required to undergo a health screen that will be conducted by a manager. **The purpose of the health screen is to help prevent the spread of COVID-19.** The screening questions are consistent with CDC guidelines, Florida Department of Business and Professional Regulation recommendations, Florida Restaurant & Lodging Association recommendations, and information about COVID-19 as of June 22, 2020. The manager conducting the health screen must complete this form. The form must be signed and dated by both the manager and employee. Completed health screen forms will be maintained in a confidential file.

1. **Did you take your temperature at home within three hours of arriving here?** ☐Yes ☐No
2. **Was your temperature below 100.4 degrees?** ☐Yes ☐No
3. **Have you had a fever in the last 48 hours?** ☐Yes ☐No
4. **Are you currently experiencing any of the following COVID-19 symptoms:** *(Symptoms are subject to change at any time based on current CDC guidance.)*

Coughing	☐Yes	☐No
Shortness of breath or difficulty breathing	☐Yes	☐No
Chills	☐Yes	☐No
Sore throat	☐Yes	☐No
Muscle pain	☐Yes	☐No
Fatigue	☐Yes	☐No
Headache	☐Yes	☐No
Congestion or runny nose	☐Yes	☐No
Nausea or vomiting	☐Yes	☐No
Diarrhea	☐Yes	☐No
New loss of taste or smell	☐Yes	☐No

5. **Have you had close contact (within 6 feet) for a prolonged period of time (15 minutes or more) with someone who has known, suspected, or possible (symptomatic) COVID-19 within the past 14 days?**

   ☐Yes ☐No Date of last contact with the individual: _____

6. **Does anyone in your home currently have symptoms of COVID-19, including a cough, shortness of breath or difficulty breathing, fatigue, headache, congestion or runny nose, nausea or vomiting, diarrhea, chills, a sore throat, muscle pain, or a new loss of taste or smell?**

   ☐Yes ☐No

7. **Have you tested positive for COVID-19 or are you presumptively positive for COVID-19 based on a health care provider's assessment?**

   ☐Yes ☐No

8. **Have you returned from international travel or a cruise within the last 14 days?** ☐Yes ☐No

9. **Have you traveled through any airport within the past 14 days?** ☐Yes ☐No

10. **Have you returned from travel to any area known to have high numbers of positive cases or substantial community spread of COVID-19, including New York, New Jersey, and Connecticut, within the past 14 days?**

    ☐Yes ☐No Location Traveled____

Screener: *(check one)*

☐ I visually inspected the employee for signs of illness and did not see any signs of illness.

☐ I visually inspected the employee for signs of illness and saw the following signs of illness:

____

* *

INSTRUCTIONS: Once the form is completed, the screener and employee must both sign and date the form.

If the employee answered "YES" to **any** of the above questions OR if the employee shows any visible signs of illness, the employee is not permitted to enter the building and must receive further instruction from the owner. In some situations, it may be necessary to obtain additional information from the employee to determine if he/she can work.

If the employee answered "NO" to **all** of the above questions and the employee does not show any signs of visible illness, the employee is permitted to work.

Screener: I certify that the information I documented on this form is true and accurate to the best of my knowledge.

Name (please print)____

Signature____Date__________________

Employee: I certify that the answers above are true and correct to the best of my knowledge.

Name (please print)____

Signature____Date__________________