COVID-19 Screening Form-2020

Name: _____

Date: _____

Building: ☐ 1st Shift ☐ Fulfillment Center
☐ 2nd Shift ☐ Farmhouse
☐ 3rd Shift

Employer: ☐ ☐ ☐ Contractor/Vendor
Company Name: _____

In response to the current COVID-19 pandemic, we require that anyone entering our Production or Warehouse facilities complete this screening form and undergo a temperature check by one our designated screeners before entering work areas.

Screening Questions:

1. In the last 3 days, have you experienced any of the symptoms listed below? ☐ Yes ☐ No

   If yes, please check all symptoms that apply:

   ☐ Fever above 100 F
   ☐ Atypical Cough (new for you or unrelated to seasonal allergies)
   ☐ Atypical Shortness of breath or difficulty breathing (new for you)
   ☐ Chills
   ☐ Muscle Pain (Unexplained)
   ☐ Sore Throat
   ☐ New loss of taste or smell

2. In the last 14 days, have you had direct close contact (within 6 feet for a prolonged period of time) with someone who has a current positive test for COVID-19 or with someone who is currently experiencing symptoms of COVID? ☐ Yes ☐ No

3. In the last 24 hours, have you experienced any illness symptoms that are not specifically listed in questions 1? ☐ Yes ☐ No
   If yes, please list your symptoms:

4. Temperature Reading at time of screening: _____

This screening form is not intended to take the place of medical advice, diagnosis or treatment.