IHG Consulting LLC

COVID-19 Health Screen - Daily

Name	

Date							
	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Temperature							
	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Have you had any of the CDC recognized Covid-19 symptoms since your last day of work?							
Cough							
Shortness of breath							
Fever							
Chills							
Muscle Pain							
Sore Throat							
New loss of taste or smell							
Is there anyone in your household showing Covid-19 symptoms?							
Is there anyone in your household who has been diagnosed with Covid-19?							
Have you been in close contact with anyone exhibiting signs or symptoms of fever, persistant cough, or shortness of breath consistant with Covid-19 who has not been tested or is still awaiting testing?							