On-Site Health & Safety
Covid- 19 Symptom Questionnaire
Per Centers for Disease Control and Prevention Guidelines

Answers to these questions are confidential and are to be reviewed only by the company's designated professional.

Company Name:		**Date:**	
Employee Name:		**Date of Birth:**	
Job Title:		**Phone Number:**	

Question	**Yes**	**No**
To the best of your knowledge have you been or near anyone exposed to COVID- 19?		
Do you have any Chronic Medical Conditions, such as Heart Disease, Diabetes, Lung Disease, etc.?		
Within the last 2-14 days have you experienced any of the below symptoms?		
Fever		
Cough		
Shortness of Breath		
Do you currently have any of the below symptoms?		
Difficulty Breathing		
Shortness of Breath		
Persistent Pain in Chest		
Pressure in Chest		
New Confusion or Inability to Arouse		
Blueish Lips		
Blueish Face		
Are you over 65, pregnant, or have a chronic lung condition, heart disease, diabetes, or on an immune suppressive medication?		

Employee Name:		**Employee Signature:**	
Technician Signature:		**Date:**	