CCT DAILY HEALTH ASSESSMENT

NAME _____

Following the mandates of EMERGENCY ORDER 2020-01, CCT will be implementing a daily health screenings for all employees who are not working from their residence.

PLEASE ANSWER THE FOLLOWING QUESTIONS. IF YOU ANSWER YES TO ANY QUESTION, PLEASE CONTACT JILL OR RYAN IMMEDIATELY.

Have you been in "Close Contact" in the last 14 days with someone with a diagnosis of COVID-19?

Yes/No If YES, please provide date of contact _____

Have you traveled in the last 14 days? (travel to other areas of state or to other states)

Yes/No If YES, please explain _____

Please indicated if you have any of the following symptoms by providing the date the symptoms began

SYMPTOMS	Cough	Shortness of Breath	Sore Throat	Diarrhea	Loss of Taste/ Smell	Fatigue	Headache or Body Aches	Nausea or Vomiting
Date of onset of symptoms								

Current Body Temperature _____ (if a non-contract thermometer is not available please take your temperature at home are self-report)

If you answered yes to any questions above; please contact your manager/supervisor immediately

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EMPLOYEE SIGNATURE _____ DATE _____

MANAGEMENT REVIEW:

REVIEWED BY: _____ DATE _____

ACTION TAKEN _____