TRI DELTA HOUSING

COVID-19 30-DAY WORKPLACE HEALTH SCREENING

Employee Name: _____ Position: _____ Location:_____

In the past 24 hours, have you experienced:

Date	Felt Feverish	New or Worsening Cough	Shortness of Breath	Sore Throat	Diarrhea	Close contact with someone who tested positive	Traveled via airplane
	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No

If you answer **"yes"** to any of the symptoms listed above, or your temperature is **100.4°F or higher**, please do not report to work. Follow CDC guidelines and contact your primary care physician's office for direction.

I confirm that I have completed this screening myself and that I have answered these questions daily and honestly upon arrival at work.

Employee Signature:	***Date:***