Daily Self Evaluation Form

Printed Name _____

I have followed the return to work guidelines ☐

I took my temperature at home and it is less than 100° Fahrenheit ☐

Are you exhibiting any symptoms of COVID-19 (Corona Virus):

A. Persistent Cough	Yes ☐	No ☐
A. Shortness of Breath	Yes ☐	No ☐
B. Chills / Shaking with chills	Yes ☐	No ☐
B. Headache	Yes ☐	No ☐
B. Sore throat	Yes ☐	No ☐
B. Loss of taste or smell	Yes ☐	No ☐
B. Muscle Pain	Yes ☐	No ☐

Signature _____ Date_____

If you have one symptom A or two of symptom B, you will need to stay home until these symptoms go away.these symptoms go away.

Signature _____ Date_____

If you have one symptom A or two of symptom B, you will need to stay home until these symptoms go away.

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Signature _____ Date_____

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