STAY and TRAIN HEALTHY

DAILY HEALTH CHECK QUESTIONNAIRE

Within the **last 10 days** have you been diagnosed with COVID-19, had a test confirming you have the virus, or been advised to self-isolate or quarantine by your doctor or a public health official?

YES ☐ NO ☐

Have you had any one or more of the following symptoms **today or within the past 24 hours**, which is not new or not explained by another reason?

- Fever/Chills
- Cough
- Shortness of breath
- Sore throat
- Fatigue
- Headache
- Muscle/body aches
- Runny nose/congestion
- New loss of taste or smell
- Nausea, vomiting or diarrhea

YES ☐ NO ☐

In the **past 14 days**, have you had close contact (within 6 ft for more than 10 minutes or being exposed to infected secretions such as being sneezed on, etc.) with an individual diagnosed with COVID-19?

YES ☐ NO ☐

Printed Name: _____ Date:_____

Signature: _____ Phone Number:_____