|  |  |  |
| --- | --- | --- |
| Visitor / Vendor Name: *(please print)* |  |  |
| Company: |  |  |
| Date & Time: |  |  |
|  |  |  |
| For everyone’s safety, we are conducting a daily COVID-19 wellness check until further notice. Please answer the following questions about your health and exposure to  COVID-19. Please circle your response (Yes or No). Any Yes answer must be discussed with management. | | | |
|  |  |  |
| Yes | In the past 24 hours, have you had a cough, fever or trouble breathing? | No |
|  |  |  |
| Yes | In the past 24 hours, have you experienced loss of smell/taste, sore throat, headache, chills or muscle pain? | No |
|  |  |  |
| Yes | In the past 24 hours, have you had contact with a person who tested positive for COVID-19? | No |
|  |  |  |
| Yes | In the past 24 hours, have you had contact with a person who displayed COVID-19 symptoms? | No |
|  |  |  |
|  |  |  |

Visitor / Vendor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Management review: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(*Initials*)

Management comments (*required for any Yes responses*): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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