BENEDICT COLLEGE
COVID -19 HEALTH SCREENING DAILY CHECKLIST
CONSULTANTS, VENDORS AND VISITORS

(This pre-work Symptom Survey must be completed prior to reporting to work each day. It is critically important that everyone working is healthy and symptom free.)

Name: ________________________________ **Date:**____________________

Department: ___________________________ **Telephone No.**____________

1. **Do you have fever (100.4), or do you feel warm, or feel chills?**

   ______YES
   ______NO

2. **Are you currently experiencing any of these symptoms or have you experienced any of these symptoms in the last 24 hours? Please check all that apply.**
   - ______Nausea
   - ______Vomiting/Diarrhea
   - ______Fever
   - ______Cough (not related to Allergies)
   - ______Abdominal Cramps
   - ______Shortness of Breath (not severe)
   - ______Repeated Shaking with Chills
   - ______Headache
   - ______Short Throat
   - ______Muscle Pain
   - ______New loss of taste or smell

3. **Are you currently ill, or caring for someone who is ill?**

   _______YES

   ________NO

   If YES, in the two weeks before you felt sick, did you: (check those that apply)

   ____Have contact with someone diagnosed with COVID-19?

   ____Live in or visit a place where COVID-19 is spreading

4. **Please input your temperature:** _________