

## DAILY COVID-19 SCREENING AND SIGN IN SHEET

**BUILDING**

**ENTRY DATE**

By signing below, I confirm that the following statement is true and correct to the best of my knowledge:

***Since my last day of work, or last visit here, I confirm that I have not had the following symptoms:***

- *Cough*
- *Shortness of breath or difficulty breathing*

***OR, Two or more of the following symptoms:***

- *Fever*
- *Chills*
- *Repeated shaking with chills*
- *Muscle Pain*
- *Headache*
- *Sore throat*
- *New loss of taste or smell*

*I understand that if I have had coughing; or shortness of breath; or difficulty breathing; or two or more of the listed symptoms since my last day of work or visit here, I must not enter the building.*

PRINTED Name	Signature	Time of Entry	Purpose	Contact #
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