COUNTY OF TRINITY
Department of Human Resources| Risk Management
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COUNTY OF TRINITY EMPLOYEE DAILY SCREENING FORM – COVID-19

Employee Name: _____

Two week period: _____

Each employee must answer the following questions each morning prior to coming into the office:

1. Have you been in close contact or staying in the same household as someone with a known or suspected case of coronavirus (COVID-19)? YES ☐ NO ☐
2. Are you ill today? YES ☐ NO ☐
3. Do you have any of the following symptoms? YES ☐ NO ☐
   - Fever
   - Cough
   - Difficulty Breathing
   - Subjective feeling of fever (body aches, chills, etc.)
4. Is your current temperature more than 100°F? YES ☐ NO ☐
5. Have you been in prolonged close contact or staying in the same household as someone with any of the above symptoms? YES ☐ NO ☐

Any YES answer to questions 1-5 requires the employee to immediately self-separate and to not enter the work area. These employees are restricted from working until they are cleared either through isolation, quarantine and/or testing of COVID-19.

1.	Date: _____	Symptoms:	☐ No	☐ Yes: _____		Initials: ____
2.	Date: _____	Symptoms:	☐ No	☐ Yes: _____		Initials: ____
3.	Date: _____	Symptoms:	☐ No	☐ Yes: _____		Initials: ____
4.	Date: _____	Symptoms:	☐ No	☐ Yes: _____		Initials: ____
5.	Date: _____	Symptoms:	☐ No	☐ Yes: _____		Initials: ____
6.	Date: _____	Symptoms:	☐ No	☐ Yes: _____		Initials: ____
7.	Date: _____	Symptoms:	☐ No	☐ Yes: _____		Initials: ____
8.	Date: _____	Symptoms:	☐ No	☐ Yes: _____		Initials: ____
9.	Date: _____	Symptoms:	☐ No	☐ Yes: _____		Initials: ____
10.	Date: _____	Symptoms:	☐ No	☐ Yes: _____		Initials: ____
11.	Date: _____	Symptoms:	☐ No	☐ Yes: _____		Initials: ____
12.	Date: _____	Symptoms:	☐ No	☐ Yes: _____		Initials: ____
13.	Date: _____	Symptoms:	☐ No	☐ Yes: _____		Initials: ____
14.	Date: _____	Symptoms:	☐ No	☐ Yes: _____		Initials: ____