**EMPLOYEE SCREENING REGISTER**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **SCREENING QUESTIONS** | **MONDAY** | **TUESDAY** | **WEDNESDAY** | **THURSDAY** | **FRIDAY** | **Saturday** | **Sunday** |
|  | Temperature | Temperature | Temperature | Temperature | Temperature | Temperature | Temperature |
|  | AM | PM | AM | PM | AM | PM | AM | PM | AM | PM | AM | PM | AM | PM |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | **YES** | **NO** | **YES** | **NO** | **YES** | **NO** | **YES** | **NO** | **YES** | **NO** | **YES** | **NO** | **YES** | **NO** |
| 1. Do you have a fever?
 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. Any new or worsening cough?
 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. Headaches & Chills?
 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. Any shortness of breath?
 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. Hoarse voice?
 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. Difficult swallowing?
 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. Unexplained fatigue?
 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. New smell or taste disorders?
 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. Any runny or nasal congestion?
 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. Any vomiting, diarrhea or abdominal pains?
 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. Have you attended funerals?
 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. Have you travelled or been in contact with someone who’s infected?
 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. Have you had close contact with anyone with respiratory illness or a probable Covid-19?
 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

Employee Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Contact No.: | Email:  | Job Title |
| Alternative Contact:  | Next of keen: | Home Address:  |