

DAILY HEALTH CHECK QUESTIONNAIRE

NAME: _____

DATE: _____

EMAIL: _____

PHONE: _____

Please Take a moment and answer the 4 questions below regarding COVID-19. If you answer yes to any of these 4 questions you will not be permitted to attend this training class. Please bring this sheet with you signed to class as your admission to get in. If the answer is yes to any of these questions, please stay home.

Circle Yes or No

1. Are you experiencing any symptoms such as fever, cough, and shortness of breath or respiratory illness? Yes or No
2. Have you been in close contact with anyone who has been diagnosed with COVID-19 in the past 14 days? Yes or No
3. Have you been in close contact with anyone who may have COVID-19, but is yet to be confirmed in the past 14 days? Yes or No
4. Are you currently in close contact with anyone, such as a family member, who is experiencing symptoms or has been confirmed as a positive for COVID-19? Yes or No

NOTE: Training room will be set-up to accommodate 6- foot social distancing. Please be respectful of other's space. Hand Sanitizer will be available. Please also bring a face mask in the event you may have to be closer than 6 feet to someone. Face mask may be worn during class, but you will not be required to keep them on if you are maintaining social distancing.

Comments/Questions: _____

SIGNATURE: _____

DATE: _____