Richfield Living

Daily COVID-19 Screening Questionnaire
For ____/____/2021

Name:_____ **Temp:**_____

☐ **RL Team Member** ☐ **Contract Team Member** ☐ **Agency** ☐ **Visitor**

Prior to entering the building, have you…

1. Experienced any of the following symptoms that cannot otherwise be attributed to another condition? **YES** ☐ **NO** ☐
   - Fever - Cough - Headache - Muscle Pain - Chills
   - Sore Throat - Nausea/Vomiting - Loss of taste or smell
   - Diarrhea -Shortness of breath/difficulty breathing
2. Tested positive for COVID-19 within the past 10 days? **YES** ☐ **NO** ☐
3. Had close contact with someone experiencing symptoms, or someone with known exposure, to COVID-19 in the past 14 days? **YES** ☐ **NO** ☐

If you answered YES to any of these questions, ask to speak with a supervisor. DO NOT ENTER THE BUILDING!

TEAM MEMBERS ONLY: By signing below, you acknowledge you are following your facilities COVID-19 TESTING REQUIREMENTS:

Signature: _____

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