| COVID-19 Health Check |
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| Details: | | |
| Name: | | Date: |
| Employee | Contractor | Email: |
| Company: | | Phone: |

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| **Location** | | | |
| Have you or a family member been identified as a close contact with someone who has been confirmed as having COVID-19? | Y | N |  |
| Are you currently under direction to isolate or quarantine? | Y | N | If yes, you are not permitted to enter our site. You must remain in isolation or quarantine. |
| Are you currently awaiting results from being tested for COVID-19? | Y | N | If yes, you are not permitted to enter our site until a negative test result can be provided. |
| Have you had any of the following symptoms in the past 14 days:   * Loss or change in sense of smell or taste * Fever * Chills or sweats * Cough * Sore throat * Shortness of breath * Runny nose | Y | N | If yes, you will need to provide a negative test result and be symptom-free for at least 24hrs prior to entering our site. |

I declare all the above to be true and correct and agree to follow all site rules including requirements for vaccinations, record keeping/scanning, distancing and any additional health measures required of me.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_