## **Employee Sign In Sheet- PLEASE WASH YOUR HANDS!!** Remember: Do not shake hands with, touch, or hug individuals Have you had at least two of these symptoms: fever, **Worked in another** repeated shaking with chills, setting with What areas of the facility were you in today? headache, diarrhea, chills, confirmed COVIDmuscle pain, sore throat, 19? vomiting, new loss of smell/taste? Date Name Time In **Time Out** Cough/Shortness of Breath **Phone Number** Yes / No Yes / No Yes / No Date Name Time In **Time Out** Yes / No Yes / No **Phone Number** Cough/Shortness of Breath Yes / No Date Name Time In Time Out Yes / No Yes / No Cough/Shortness of Breath **Phone Number** Yes / No Date Name Time In Time Out Yes / No Yes / No Cough/Shortness of Breath **Phone Number** Yes / No **Time Out** Date Name Time In Yes / No Yes / No **Cough/Shortness of Breath Phone Number** Yes / No Date Name Time In **Time Out** Yes / No Yes / No **Cough/Shortness of Breath Phone Number** Yes / No Date Time In **Time Out** Name Yes / No Yes / No Phone Number **Cough/Shortness of Breath** Yes / No

Please monitor yourself for signs and symptoms of infection (Cough, shortness of breath, Fever, repeated shaking with chills, headache, diarrhea, chills, muscle pain, sore throat, vomiting, new loss of smell/taste).

	S	houl	d	any symp	toms occur, p	lease notify	<i>ı</i> us immediatel <sup>,</sup>	y at
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