# COVID-19 Symptom Checklist

**Name:**_____ **Date:** _____

**Screener:**_____ **Entrance:** _____

**Temperature:** _____

| Questions? | YES | NO |
|---|---|---|
| **Do you have a fever?** | | |
| **Do you have a cough?** | | |
| **Do you have shortness of breath?** | | |
| **Are you experiencing fatigue?** | | |
| **Do you have muscle aches?** | | |
| **Do you have a new loss of tastes or smell?** | | |
| **Have you been in contact with anyone that has tested positive for COVID-19?** | | |
| **Have you traveled outside of the U.S. recently? If yes, when? Where to?** | | |
| **Do you agree to report the onset of any of these symptoms during your shift?** | | |
| **Have you answered these questions truthfully and to the best of your knowledge?** | | |

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**The Machinists Institute**