

Company: _____ Date: _____ Time: _____

Individual Identifier: _____ Type: _____
(Number on Document) (License, Passport, ID, etc.)

SCREENING QUESTIONNAIRE

1. Are you currently experiencing, or have you experienced in the past 14 days, any of the following symptoms?
 - a. Fever (100.4° F/37.8° C or greater as measured by an oral thermometer) Yes No
 - b. Cough Yes No
 - c. Shortness of breath or difficulty breathing Yes No
 - d. Sore throat Yes No
 - e. New loss of taste or smell Yes No
 - f. Chills Yes No
 - g. Head or muscle aches Yes No
 - h. Nausea, diarrhea, vomiting Yes No

2. In the past 14 days, have you been in close proximity to anyone who was experiencing any of the above symptoms or has experienced any of the above symptoms since your contact? Yes No

3. In the past 14 days, have you been in close proximity to anyone who has tested positive for COVID-19? Yes No

4. In the past 14 days, have you been on a commercial flight or traveled outside of the United States? Yes No

5. Do you have any medical condition that would cause your temperature to read above 99.8°F? Yes No

ASSESSMENT
[To be completed by ParaDocs Personnel]

Temperature Check at entry point	<input type="checkbox"/> °F <input type="checkbox"/> °C	
Temperature Check #2 (if needed)	<input type="checkbox"/> °F <input type="checkbox"/> °C	
Access to worksite (check one)	<input type="checkbox"/> Approved <input type="checkbox"/> Denied	
Temperature Check at departure	<input type="checkbox"/> °F <input type="checkbox"/> °C	
Departure (Date & Time)		