Company Name

Employee COVID-19 Daily Screening

In order for you to work in-person at a (Company Name) location, you must complete this screening DAILY before entering the workspace. If you answer YES to any question, you are NOT permitted to work in the office. This is to assure the safety of all Viking team members.

Please note: Information collected in this questionnaire will be kept confidential, it will not be shared with anyone outside of Human Resources and it will be maintained in an individuals' confidential medical file.

1. **Do you have a cough or difficulty breathing that is not typical for you? (Select one option)**

   ☐ YES

   ☐ NO

2. **You must take your temperature today. Do you have a fever or a temperature that is higher than normal for you? (Select one option)**

   ☐ YES

   ☐ NO

3. **Do you or anyone in your household have the symptoms of a cold or the flu, such as chills, body ache, sore throat, etc.? (Select one option)**

   ☐ YES

   ☐ NO

4. **Have you been diagnosed as having COVID-19 within the last 14 days? (Select one option)**

   ☐ YES

   ☐ NO

5. Have you been in contact with anyone who has been diagnosed as having COVID-19 within the last 14 days? (Select one option)

☐ YES

☐ NO

6. Do you have anyone in your household who is under quarantine? (Select one option)

☐ YES

☐ NO

7. Please provide your full name:

8. Today's date: