DAILY HEALTH SCREENING QUESTIONAIRE

Name: ______________________________

Date Of Birth: ____________________

Today's Date: ____________________

Temperature: ____________________ (must be less than 100.4º)

ARE YOU EXPERIENCING ANY OF THE FOLLOWING?

Loss or decrease in the sense of smell?	Yes	No
Loss or decrease of the sense of taste?	Yes	No
Fever - temperature of 100º or higher?	Yes	No
Cough?	Yes	No
Congestion?	Yes	No
Runny nose?	Yes	No
Sore throat?	Yes	No
Shortness of breath?	Yes	No
Body aches?	Yes	No
Headache?	Yes	No

If you have answered yes to any of the above questions or have had any of these symptoms in the last 72 hours contact your supervisor and seek medical evaluation prior to starting your shift.

LAKE FOREST
ACUTE CARE
WALK-IN URGENT CARE
1025 W. EVERETT RD. LAKE FOREST, IL. 60045

Phone 847.234.7950

MONDAY - FRIDAY : 8AM - 6PM
SATURDAY : 8AM - 2PM
SUNDAY : 12PM - 6PM

www.LFACUTECARE.com