COVID-19 DAILY WORKER HEALTH DECLARATION

COVID-19 DAILY WORKER HEALTH DECLARATION

DATE: _____

NAME: _____ DEPARTMENT: _____

PRODUCTION: _____

Check applicable boxes below

	YES	NO
Have you or anyone in your household travelled internationally in the past 14 days?		
Have you been in contact with anyone suspected or confirmed to have COVID-19 in the past 14 days?		

Please state whether you or any of your household members are experiencing any of the following symptoms:					
	YES	**NO**		**YES**	**NO**
Fever above 38°C/100°F			**Loss of sense of smell or taste**		
Sneezing			**Sore throat**		
Difficulty breathing			**Non-allergy related runny nose**		
Dry cough			**Muscle aches**		

If you are experiencing any of the above symptoms, you must immediately contact your health care professional or 811 for recommended next steps and notify the appropriate production contact person (e.g. department head, COVID-19 safety officer).

BC COVID-19 Symptom Self-Assessment Tool: bc.thrive.health/covid19/en

If you experience any of the above symptoms after completing this form, report to your supervisor and follow their instructions.

I certify that, to the best of my knowledge, the information I've given is accurate and complete.

Signature (worker): _____ Date of Signature: _____

The information collected on this form will only be disclosed upon lawful request, for example, to the Public Health Office for the purposes of contact tracing.

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