# Health Assessment Form

Date of assessment:

## Employee Information

Full name

Department

Email

Phone #

## Symptoms

Have you travelled internationally within the last 14 days?

☐ Yes ☐ No

Have you had contact with anyone with confirmed COVID-19 in the last 14 days?

☐ Yes ☐ No ☐ Unsure

Please check the box of each symptom you are currently experiencing or have had in the last 14 days:

| | Yes | No | Additional details |
|---|---|---|---|
| Fever, chills, sweating | ☐ | ☐ | |
| Difficulty breathing | ☐ | ☐ | |
| New or worsening cough | ☐ | ☐ | |
| Sore throat | ☐ | ☐ | |
| Body aches | ☐ | ☐ | |
| Vomiting or diarrhea | ☐ | ☐ | |
| None of the above | ☐ | | |

Please select all conditions that apply to you:

| | Yes | No | Additional details |
|---|---|---|---|
| Asthma or lung disease | ☐ | ☐ | |
| Pregnant | ☐ | ☐ | |
| Weakened immune system | ☐ | ☐ | |
| Cirrhosis of the liver | ☐ | ☐ | |
| Kidney failure | ☐ | ☐ | |
| Congestive heart failure | ☐ | ☐ | |
| Obesity | ☐ | ☐ | |
| Diabetes | ☐ | ☐ | |
| None of the above | ☐ | ☐ | |

Employee signature

Date