COVID-19 Daily Self Checklist

REVIEW THIS COVID-19 CHECKLIST EACH DAY BEFORE STARTING WORK. Submit to your temperature tester.

Name ____

Date ____

Do you have any of the following symptoms?

Symptom	Yes	No
Fever	☐	☐
Runny nose	☐	☐
Sore throat	☐	☐
Cough	☐	☐
Chills or sweats	☐	☐
Shortness of breath	☐	☐
Loss of sense of smell or taste	☐	☐

Have you, or anyone you have been in close contact with, been diagnosed with COVID19? Yes ☐ No ☐

Have you travelled to any other areas of Victoria in the past 14 days? Yes ☐ No ☐

I honestly declare that the answers on this checklist are true and correct

____ (Signature)