ADT Attendance Screening

Participant	Date of Return	Date of COVID Test	Documentation	Date:	Date:	Date:	Date:	Date:
			YES / NO	Temp:	Temp:	Temp:	Temp:	Temp:
Have you had any of the symptoms below since your last day at work or last day here at Day Training?								
• Felling of fever?				YES / NO	YES / NO	YES / NO	YES / NO	YES / NO
• Cough				YES / NO	YES / NO	YES / NO	YES / NO	YES / NO
• Shortness of Breathe				YES / NO	YES / NO	YES / NO	YES / NO	YES / NO
• Sore Throat				YES / NO	YES / NO	YES / NO	YES / NO	YES / NO
• Muscle Aches				YES / NO	YES / NO	YES / NO	YES / NO	YES / NO
• Change in sense of smell or taste				YES / NO	YES / NO	YES / NO	YES / NO	YES / NO
• Any gastrointestinal symptoms (diarrhea, vomiting, etc.)				YES / NO	YES / NO	YES / NO	YES / NO	YES / NO
Is there anyone in your household who is ill or has been diagnosed with COVID-19?				YES / NO	YES / NO	YES / NO	YES / NO	YES / NO
Have you been in contact with anyone who is ill or has been diagnosed with COVID-19?				YES / NO	YES / NO	YES / NO	YES / NO	YES / NO

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• Muscle Aches				YES / NO	YES / NO	YES / NO	YES / NO	YES / NO
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