Daily Health Check Form

Date: _____

Individual's Information:

- **Full Name: _____**
- **Contact Number: _____**
- **Department/Group: _____**

Checklist of Symptoms (Check all that apply):

- **☐ Fever**
- **☐ Cough**
- **☐ Shortness of Breath**
- **☐ Sore Throat**
- **☐ Body Aches**
- **☐ Loss of Taste or Smell**
- **☐ Other: _____**

Recent Contact:

- **Have you been in contact with anyone diagnosed with a communicable disease in the last 14 days? ☐ Yes ☐ No**

Action Taken (For Supervisor/Health Officer Use):

Time	Symptoms Observed	Decision	Remarks

Acknowledgment by Individual:

I confirm that the above information is accurate to the best of my knowledge.

Signature: _____

Date: _____