**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**