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EMPLOYEE DAILY HEALTH SCREENING FORM

Complete and return this form to your supervisor <u>before every shift</u>.

Employee Name:_____ Date:_____

Dept: ***Please circle your applicable department group***

Ambassador	Bar	Cabin Office	Custodian
Customer Service	Food & Beverage	Lifts	Management
Mountain Ops	Mountain School	Patrol	Parking Attendant
Race	Retail	Rentals	Tubing Attendant
Tubing Tickets	Tuning		

(1) Have you had any known close contact a person confirmed or suspected to have COVID-19 or in the past 14 days?

(2) Are you experiencing any of the following symptoms: cough, shortness of breath, chills, headache, fever, new loss of taste or smell, trouble breathing, muscle pain, sore throat?

(3) Have you tested positive for COVID-19 through a diagnostic test in the past 14 days?

(4) Have you traveled within a state, which is currently on the travel advisory list, for longer than 24 hours in the past 14 days?

◯ **NO to all questions above**

◯ **YES to at least one of the above questions**

If you answer "YES", you <u>cannot</u> come to work.

Contact your supervisor <u>ASAP</u>.

Employee Signature: _____
(over 18 years of age)

Parent/Guardian Name:_____Signature:_____

All Employees under the age of 18 *<u>MUST</u>* have a parent's signature.
NO EXCEPTIONS!