

Dental Office Staff Daily Screening Form

Date: _____

All dental office staff must confirm their absence of symptoms and have temperature taken each day. If symptoms are present, further investigation is needed by the managing dentist.

Name: _____		Signature: _____		
• Fever > 38° C	YES NO	• Difficulty breathing	YES NO	AM Temperature _____
• Cough	YES NO	• Flu-like symptoms	YES NO	
• Sore throat	YES NO	• Runny nose	YES NO	PM Temperature _____
• Shortness of breath	YES NO			

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• Sore throat	YES NO	• Runny nose	YES NO	PM Temperature _____
• Shortness of breath	YES NO			

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