

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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