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COVID-19 Symptom Incident Report

Location	
Date & Time	
Employee or Child's Name	
Symptoms	
Action Taken including reference to PPE used	
Time individual left premises	
COVID-19 Test Completed	Y/N
Test Result (if applicable)	Positive/Negative
Date of Result	

If negative:

Date of return		
Employee or Guardian Name:	Signature:	Date:
Manager's Name:	Signature:	Date:

COVID-19 Symptom Incident Report

If positive, complete the following section:

Action taken following result	
Names of Employees required to isolate	
Names of children required to isolate	
Did any of the above experience symptoms or test positive for COVID-19	

Date of return		
Employee or Guardian Name:	Signature:	Date:
Manager's Name:	Signature:	Date: