COVID-19 MONITORING FORM

Date: ________________

NAME	PHONE/EMAIL	TIME	Fever		Cough		Sore Throat		Shortness Breath		Contact		Temp ✓ If over 100.3
			YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	
			YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	
			YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	
			YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	
			YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	
			YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	
			YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	
			YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	
			YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	
			YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	
			YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	
			YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	
			YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	
			YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	
			YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	
			YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	
			YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	
			YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	

- **Fever:** Have you had a fever or chills in the last 72 hours?
- **Cough:** Do you have a persistent wet or dry cough?
- **Sore Throat:** Do you have a sore throat or a runny/stuffy nose?
- **Shortness of Breath…:** Are you experiencing unusual shortness of breath, fatigue, loss of sense or smell, headache, or muscle pain?
- **Contact:** Have you had close contact with someone with COVID-19 in the last 14 days? Are you or someone in your household awaiting a COVID-19 test result?