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 in the last 72 hours

Cough: Do you have a persistent cough

Sore Throat: Do you have a sore throat

Shortness Breath: Are you experiencing unusual shortness of breath

Contact: Have you had close contact with someone with COVID-19 in the last 14 days