SELF MONITORING FORM

Name: _____ Date symptoms started (if applicable): _____

Self-monitoring Start Date: _____

** Avoid the use of fever-reducing medicines (e.g., acetaminophen/Tylenol, ibuprofen/Advil) as much as possible. Fever-reducing medicines could hide early symptoms; if these must be taken, speak with your health care provider. Pay attention to your health. If you develop any symptoms write YES or NO below for each symptom daily.*

Self-monitoring day	1	2	3	4	5	6	7	8
Date (MM/DD)								
Daily temperature (degrees Celsius) °C °								
✓ **NO SYMPTOMS**								
Chills								
Conjunctivitis								
(pink eye)								
Cough								
Diarrhoea								
(loose stool/poop)								
Fatigue (tired)								
Runny nose								
Short of breath or								
difficulty breathing								
Sore throat								
Other (add in notes) loss of appetite, loss of taste or sense of smell, nausea & vomiting, muscle aches, headache, new chest								

NOTES:

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