|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **DATE** | **NOM** | **TEMPÉRATURE**  | **Toux sèche, Essoufflement, difficulté à respirer :** **oui = Masque** | **Observations / Actions** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |