Name ______________________________

Day: Monday Tuesday Wednesday Thursday Friday Sat/Sun

Date: ______________________________________

In the past 72 hours, Have you had any one of these symptoms?

Y___ N ___ Fever; Cough; Chills; and/or Muscle Aches?

Y___ N ___ Sore Throat; Runny Nose; and/or Loss of taste or smell?

Y___ N ___ Nausea; Vomiting; and/or Diarrhea?

Y___ N___ Shortness of Breath and/or Headache?

Y___ N___ Had Close contact, or cared for someone with COVID-19?

Temp Higher than 100.4

Staff ____________________

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