

COVID-19 DAILY SYMPTOM MONITORING CHECK



Name		Support Location	
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Early detection is critical to ensure appropriate medical support. Tracking observable symptoms provide the baseline of necessary information for medial professionals if required. Symptoms may develop up to 14 days after exposure.

Symptom checks will be increased from twice a day to four times a day when there is a suspected or confirmed case at the location.

**COVID-19 SYMPTOMS INCLUDE FEVER (APPROXIMATELY 37.8°C/100.04°F),
NEW OR WORSENING COUGH, SHORTNESS OF BREATH, OR OTHER SYMPTOMS ***

If fever OR another symptom is present IMMEDIATELY follow guidance in **STEP 2: Supporting Someone Suspected to Have COVID-19** in the flowchart for people supported on covid19.chconnect.org (also posted at the program location).

	DATE: /2020				DATE: /2020				DATE: /2020			
	1 st Daily Check	2 nd Daily Check	3 rd Daily Check	4 th Daily Check	1 st Daily Check	2 nd Daily Check	3 rd Daily Check	4 th Daily Check	1 st Daily Check	2 nd Daily Check	3 rd Daily Check	4 th Daily Check
	AM	AM	PM	PM	AM	AM	PM	PM	AM	AM	PM	PM
Temperature												
New/worsening: Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Shortness of breath</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Other symptoms*</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Describe "other symptoms"												
Staff Initials (PRINT)												

***OTHER SYMPTOMS MAY INCLUDE NEW OR WORSENING SORE THROAT; DIFFICULTY SWALLOWING; RUNNY, STUFFY, OR CONGESTED NOSE (NOT RELATED TO SEASONAL ALLERGIES OR OTHER KNOWN CAUSES OR CONDITIONS); LOSS SENSE OF TASTE OR SMELL; NAUSEA/VOMITING, DIARRHEA, ABDOMINAL PAIN, OR ATYPICAL SYMPTOMS SUCH AS UNEXPLAINED FATIGUE; DELIRIUM; INCREASED FALLS; ACUTE FUNCTIONAL DECLINE; EXACERBATION OF CHRONIC CONDITIONS; CHILLS; HEADACHES; CROUP AND CONJUNCTIVITIS.**