

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 medical 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 (dd/mm/YY)														
Temperature 1 st Daily Check														
Temperature 2 nd Daily Check														
Temperature 3 rd Daily Check														
Temperature 4 th Daily Check														
New or 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Shortness of breath	<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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other symptoms*	<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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Describe "Other Symptoms"														
Staff Initials														

***OTHER SYMPTOMS MAY INCLUDE**

1 of: Fever, Loss of Taste or Smell,

2 of: Difficulty Swallowing, Digestive Issues (with no other known cause), Extreme Tiredness, Sore Throat, Headache, Muscle Aches.

