

COVID-19 HCP Symptom Monitoring Tracking Form

Case ID

Name

Address

County

Where did exposure occur?

Age (yrs.)

City

Sex

Telephone number

Date of last exposure (mm/dd/yyyy)

Day number (after discharge)	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Date														
Time AM														
Temperature AM														
Time PM														
Temperature PM														
Cough (Y/N)														
Shortness of breath (Y/N)														
Other lower respiratory symptoms (specify)														
Other symptoms (non respiratory [specify])														
Fever/Pain Reducers ¹ (Y/N)														
Staff initials														

1: Aspirin, Tylenol® (acetaminophen), or MOTRIN® (ibuprofen). If Yes, please indicate medication in Additional Notes section

Enter Date and Any Additional Notes: