

Daily COVID-19 Self-Assessment

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_

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| --- | --- |
| NO YES  | Did you either test positive or are you still awaiting results from your most recent COVID-19 test? |
| NO YES  | Have you been in contact with someone diagnosed with COVID-19 in the past 14 days? |
| NO YES  | Are you experiencing any new cough (new onset or worsening of chronic cough)? |
| NO YES  | Are you experiencing any new shortness of breath or difficulty breathing? |
| NO YES  | Are you experiencing any new muscle or body aches? |
| NO YES  | Are you experiencing any new nausea or vomiting? |
| NO YES  | Are you experiencing any new fever > 100.4° F and chills? |