COVID-19 Active Symptom Checklist

Please complete this checklist daily. This form is optimized for printing and manual record-keeping.

Personal Information

Full Name:

Date (MM/DD/YYYY): MM/DD/YYYY

Current Temperature: e.g., 98.6Â°F

Symptom Assessment

Please type "Yes" or "No" for each of the following symptoms experienced within the last 24 hours:

- Fever or chills: Yes / No
- Cough: Yes / No
- Shortness of breath or difficulty breathing: Yes / No
- Fatigue: Yes / No
- Muscle or body aches: Yes / No
- Headache: Yes / No
- New loss of taste or smell: Yes / No
- Sore throat: Yes / No
- Congestion or runny nose: Yes / No
- Nausea or vomiting: Yes / No
- Diarrhea: Yes / No

Exposure History

Have you been in close contact with anyone diagnosed with COVID-19 in the past 14 days? Yes / No

Signatures

Signature: