Date of Exposure: \_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Place an X to mark symptoms, - to mark no symptoms. If you develop fever or symptoms contact your healthcare provider and the Medical Officer.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **DAY** | **1** | **2** | **3** | **4** | **5** | **6** | **7** |
| DATE |  |  |  |  |  |  |  |
|  | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM |
| Temperature | | | | | | | | | | | | | | |
| Fever today? | | | | | | | | | | | | | | |
| Cough? | | | | | | | | | | | | | | |
| Shortness of breath? | | | | | | | | | | | | | | |
| Chest Pain? | | | | | | | | | | | | | | |
| Loss of sense of smell or taste? | || | || | || | || | || | || | || |
| Other |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **DAY** | **8** | **9** | **10** | **11** | **12** | **13** | **14** |
| DATE |  |  |  |  |  |  |  |
|  | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM |
| Temperature | | | | | | | | | | | | | | |
| Fever today? | | | | | | | | | | | | | | |
| Cough? | | | | | | | | | | | | | | |
| Shortness of breath? | | | | | | | | | | | | | | |
| Chest Pain? | | | | | | | | | | | | | | |
| Loss of sense of smell or taste? | || | || | || | || | || | || | || |
| Other |  |  |  |  |  |  |  |