

DAILY FEVER SELF-MONITORING LOG

Monitor yourself for fever (>100.4°F,38°C) twice daily for 14 days. Mark the date, time you took your temperature (mark whether it was AM or PM), and temperature. Monitor yourself for the symptoms listed below daily, as well. If you develop any of the symptoms immediately call your local health department. If you need immediate care in an emergency department notify EMS that you may have been exposed to COVID-19.

Day	Date	Time Taken	Temperature
1		_____ <input type="checkbox"/> AM <input type="checkbox"/> PM	_____°F
		_____ <input type="checkbox"/> AM <input type="checkbox"/> PM	_____°F
2		_____ <input type="checkbox"/> AM <input type="checkbox"/> PM	_____°F
		_____ <input type="checkbox"/> AM <input type="checkbox"/> PM	_____°F
3		_____ <input type="checkbox"/> AM <input type="checkbox"/> PM	_____°F
		_____ <input type="checkbox"/> AM <input type="checkbox"/> PM	_____°F
4		_____ <input type="checkbox"/> AM <input type="checkbox"/> PM	_____°F
		_____ <input type="checkbox"/> AM <input type="checkbox"/> PM	_____°F
5		_____ <input type="checkbox"/> AM <input type="checkbox"/> PM	_____°F
		_____ <input type="checkbox"/> AM <input type="checkbox"/> PM	_____°F
6		_____ <input type="checkbox"/> AM <input type="checkbox"/> PM	_____°F
		_____ <input type="checkbox"/> AM <input type="checkbox"/> PM	_____°F
7		_____ <input type="checkbox"/> AM <input type="checkbox"/> PM	_____°F
		_____ <input type="checkbox"/> AM <input type="checkbox"/> PM	_____°F

Day	Date	Time Taken	Temperature
8		_____ <input type="checkbox"/> AM <input type="checkbox"/> PM	_____°F
		_____ <input type="checkbox"/> AM <input type="checkbox"/> PM	_____°F
9		_____ <input type="checkbox"/> AM <input type="checkbox"/> PM	_____°F
		_____ <input type="checkbox"/> AM <input type="checkbox"/> PM	_____°F
10		_____ <input type="checkbox"/> AM <input type="checkbox"/> PM	_____°F
		_____ <input type="checkbox"/> AM <input type="checkbox"/> PM	_____°F
11		_____ <input type="checkbox"/> AM <input type="checkbox"/> PM	_____°F
		_____ <input type="checkbox"/> AM <input type="checkbox"/> PM	_____°F
12		_____ <input type="checkbox"/> AM <input type="checkbox"/> PM	_____°F
		_____ <input type="checkbox"/> AM <input type="checkbox"/> PM	_____°F
13		_____ <input type="checkbox"/> AM <input type="checkbox"/> PM	_____°F
		_____ <input type="checkbox"/> AM <input type="checkbox"/> PM	_____°F
14		_____ <input type="checkbox"/> AM <input type="checkbox"/> PM	_____°F
		_____ <input type="checkbox"/> AM <input type="checkbox"/> PM	_____°F

You should also monitor yourself daily for the following symptoms. The symptoms can also be recorded daily on the chart on the next page.

- | | | | | |
|--|--|--|---|-----------------------------------|
| <input type="checkbox"/> Fever (>100.4°F,38°C) | <input type="checkbox"/> Chills or severe shivering (rigors) | <input type="checkbox"/> Muscle Aches | <input type="checkbox"/> Weakness or malaise | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Sore throat | <input type="checkbox"/> Cough | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Difficulty breathing | |
| <input type="checkbox"/> New loss of smell or taste disorder | | <input type="checkbox"/> Diarrhea | | |

SYMPTOM SELF-MONITORING LOG

While monitoring yourself for fever twice daily for 14 days, also monitor yourself for the following symptoms. If you develop any of the symptoms immediately call your local health department. If you need immediate emergency care notify EMS that you may have been exposed to COVID-19.

Signs & symptoms	Day 1 __/ __	Day 2 __/ __	Day 3 __/ __	Day 4 __/ __	Day 5 __/ __	Day 6 __/ __	Day 7 __/ __	Day 8 __/ __	Day 9 __/ __	Day 10 __/ __	Day 11 __/ __	Day 12 __/ __	Day 13 __/ __	Day 14 __/ __
Fever (>100.4°F or 38.0°C) <i>(Record highest temp.)</i>	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Chills / Rigors (Shivering)	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Muscle Aches	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Weakness or malaise	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Headache	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Sore Throat	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Cough	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Shortness of breath or difficulty breathing	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
New loss of smell or taste disorder	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Diarrhea (> 3 loose stools in a 24 hours)	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Comments:														