COVID-19 HCP Symptom Monitoring Tracking System

Name:_____ Department/Unit:_____

- **Every** member of the Medical Staff as well as every employee must document on this form at the start of each shift and/or before entering the hospital/office. This is required by DOH regulation.
- If upon completing this form you answer "yes" to any of the BELOW symptoms, notify the Infection Control office. For off-sites, notify your manager for further direction.
- ****Temperature greater than 100.0 as well as any other positive symptoms noted on this form, please DO NOT report to work. Contact the Infection Control Office at ext. 1138 during normal business hours as well as your primary care provider**

DATE	TIME AM	TEMPERATURE AM	HAVE YOU HAD ANY UN-MASKED CONTACT WITH ANY PERSON, INCLUDING HEALTHCARE WORKERS, WITH LABORATORY CONFIRMED COVID-19 IN THE PAST WEEK?	DO YOU HAVE ANY OF THE FOLLOWING: COUGH, NAUSEA, VOMITING, DIARRHEA, LOSS OF TASTE OR SMELL, SHORTNESS OF BREATH, *HEADACHES, CONGESTION, RUNNY NOSE, **FEVER, (OR ANY OTHER CONCERNING SYMPTOMS)	SUPERVISOR (REVIEWER'S) INITIALS

*For headaches, congestion and runny nose, please indicate if acute onset (not a chronic symptom) and if not alleviated with allergy medication.

**If Aspirin, Tylenol® (acetaminophen), or MOTRIN® (ibuprofen) have been taken to treat these symptoms, please indicate medication in Additional Notes section.

Clarify Other Symptoms/Additional Notes: