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 say 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 Employee Health Office at ext. 1138 during normal business hours as well as your primary care provider**

DATE	TIME AM	TEMPERATURE AM	HAVE YOU LIVED OR TRAVELED TO A STATE WITH A HIGH COVID-19 PREVALENCE IN THE LAST 30 DAYS?	ANY INTERNATIONAL TRAVEL WITHIN THE LAST 14 DAYD?	HAVE YOU HAD ANY CONTACT WITH ANY PERSON, INCLUDING HEALTHCARE WORKERS, WITH LABORATORY CONFIRMED COVID-19?	DO YOU HAVE ANY OF THE FOLLOWING: COUGH, NAUSEA, VOMITING, DIARRHEA, FEVER, RASH, SHORTNESS OF BREATH**	TIME PM	TEMPERATURE PM

**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:

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