COVID-19 Daily Health Assessment

Name

Date

Are you experiencing any of the following symptoms?

☐ Fever or chills ☐ Cough ☐ Shortness of breath ☐ Muscle or body aches ☐ Loss of taste or smell ☐ Sore throat ☐ None

Have you had close contact with a confirmed COVID-19 case in the past 14 days?

○ Yes ○ No

Have you traveled internationally in the last 14 days?

○ Yes ○ No