NAME ______________________________ **SUPERVISOR** ______________________________

LOCATION (specific as possible) ______________________________

FILL IN EVERY (approx) 12 Hours

DO YOU HAVE ANY OF THESE SYMPTOMS (Yes/No for each)										
Date	Time (AM)	Time (PM)	Cough	Shortness of Breath	Chills	Muscle Pain	Loss of taste/ smell	Diarrhea	Your Temperature (F)	Comments