University of Montana FIELD RESEARCH COVID-CHECK LOG

(3/31/21 version)

Name: _____ Supervisor: _____

Location: _____ Your Signature: _____

*** To be completed at roughly 24-hour intervals ***

Date:	Time (AM/PM):	Temp (F):	**Do you have any of the following symptoms? (Y/N):** Fever, chills, cough, shortness of breath, fatigue, muscle or body aches, headaches, sore throat, new loss of taste or smell, congestion or runny nose, difficulty breathing, nausea or vomiting, diarrhea. **If yes, which one(s):**	Comments: