	HEALTH MONITORING CHECKLIST					
Name						
Sex:	M_____	F_____	Age:____			
	Day 1	**Day 2**	**Day 3**	**Day 4**	**Day 5**	**Day 6**
Date:						
Symptoms:						
Body Temperature twice/day						
a.m.						
p.m.						
Cough						
Runny nose						
Sore throat						
shortness of breath						
Diarrhea >2 loose stools/day						
Vomiting						
Abdomenal Pain						
Headache						
Body Ache						
Loss of Taste or Smell						
Oxygen Saturation						
Other						
Day 1 is onset of symptoms						

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Day 7	**Day 8**	**Day 9**	**Day 10**	**Day 11**	**Day 12**	**Day 13**	**Day 14**