**COVID-19 DAILY QUESTIONNAIRE**

**NAME:** **TEAM:**

TODAY'S DATE:

Body Temperature:

Temperature Reading Date:

Temperature Reading Time:

In the last 48 hours, have you had any of the following NEW symptoms? Please circle the correct answer:

| | |
|---|---|
| Fever | Yes/No |
| Cough | Yes/No |
| Trouble breathing, shortness of breath or severe wheezing | Yes/No |
| Chills or repeated shaking with chills | Yes/No |
| Muscle Aches | Yes/No |
| Sore Throat | Yes/No |
| Loss of smell or taste, or a change in taste | Yes/No |
| Nausea, vomiting or diarrhea | Yes/No |
| Headache | Yes/No |
| Fatigue | Yes/No |

In the last two weeks, did you care for or have close contact with someone diagnosed with COVID-19? Yes/No