Daily Self-Monitoring Form for COVID-19

Name: _____ **Date symptoms started (if applicable):** _____
Self-monitoring start date: _____ (e.g., date arrived in Canada or date of last exposure to a COVID-19 case)

***** Avoid the use of fever-reducing medicines (e.g., acetaminophen/Tylenol, ibuprofen/Advil) as much as possible. Fever-reducing medicines could hide early symptoms; if these must be taken, speak with your health care provider.

Self-monitoring day	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**
Date (MM/DD)														
Daily temperature* (degrees Celsius)	**°C**	**°C**	**°C**	**°C**	**°C**	**°C**	**°C**	**°C**	**°C**	**°C**	**°C**	**°C**	**°C**	**°C**
NO SYMPTOMS ✔														
Pay attention to your health. If you develop any symptoms write **YES** or **NO** below for each symptom daily.														
Chills														
Conjunctivitis (pink eye)														
Cough														
Diarrhoea (loose stool/poop)														
Fatigue (tired)														
Runny nose														
Short of breath or difficulty breathing														
Sore throat														
Other (add in notes) loss of appetite, loss of taste or sense of smell, nausea & vomiting, muscle aches, headache, new chest pain etc.														

NOTES: