

LOCATION:

INFECTIOUS CONTROL CHECKLIST

YEAR: _____

DATE	TIME	SYMPTOMS PRESENT: COUGHING, DIFFICULTY BREATHING, CHILLS, SORE THROAT, LOSS OF SENSE OF SMELL OR TASTE, EXTREME FATIGUE (YES/NO)	TEMPERATURE TAKEN (Checkmark ✓ for Yes)	SIGNATURE OF PERSON THAT TOOK TEMPERATURE



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