PRE-SHIFT WELLNESS LOG

1. In the past 24 to 48 hours, have you experienced:

Symptom	Yes	No
Fever (temperature above 100.4 F)		
New loss of smell and/or taste		
Sore throat		
Chills		
Cough		
Vomiting *(non-pregnancy related)*		
Fatigue*		
Diarrhea*		
Sneezing*		
Headaches*		
Muscle aches & pains*		
Difficulty breathing*		

**out of the ordinary; not associated with some other known & non-contagious condition*

2. Have you been in close contact with anyone who has exhibited symptoms of COVID-19? ☐ Yes ☐ No

3. Have you recently been in contact with anyone who has tested positive for COVID-19? ☐ Yes ☐ No

I attest that this information is true & correct.

Name _____

Signature _____

Date _____