Client Daily Temperature and Caregiver Confirmation
COVID-19 Symptom Log rev. 7/22/2021

Client Name: _____ Site:_____

Date	AM Temp	Initials	PM Temp	Initials	Does the individual show signs of symptoms associated with COVID-19 **(fever, cough, difficulty breathing, runny nose, congestion, sore throat, nausea, diarrhea, vomiting, chills, or head or muscle aches.)**	**Arrival Caregiver Confirmation** **1. My child does not have any of the following symptoms: fever, cough, difficulty breathing, runny nose, congestion, sore throat, nausea, diarrhea, vomiting, chills, or head or muscle aches.** **2. No one in my household has any of the above symptoms.** **3. No one in my household has travelled outside the country in the last 14 days.**
					AM: Yes ____ No _____ PM: Yes ____ No _____	Yes ____ No _____ Caregiver Initials _____
					AM: Yes ____ No _____ PM: Yes ____ No _____	Yes ____ No _____ Caregiver Initials _____
					AM: Yes ____ No _____ PM: Yes ____ No _____	Yes ____ No _____ Caregiver Initials _____
					AM: Yes ____ No _____ PM: Yes ____ No _____	Yes ____ No _____ Caregiver Initials _____
					AM: Yes ____ No _____ PM: Yes ____ No _____	Yes ____ No _____ Caregiver Initials _____
					AM: Yes ____ No _____ PM: Yes ____ No _____	Yes ____ No _____ Caregiver Initials _____
					AM: Yes ____ No _____ PM: Yes ____ No _____	Yes ____ No _____ Caregiver Initials _____
					AM: Yes ____ No _____ PM: Yes ____ No _____	Yes ____ No _____ Caregiver Initials _____
					AM: Yes ____ No _____ PM: Yes ____ No _____	Yes ____ No _____ Caregiver Initials _____
					AM: Yes ____ No _____ PM: Yes ____ No _____	Yes ____ No _____ Caregiver Initials _____
					AM: Yes ____ No _____ PM: Yes ____ No _____	Yes ____ No _____ Caregiver Initials _____
					AM: Yes ____ No _____ PM: Yes ____ No _____	Yes ____ No _____ Caregiver Initials _____
					AM: Yes ____ No _____ PM: Yes ____ No _____	Yes ____ No _____ Caregiver Initials _____
					AM: Yes ____ No _____ PM: Yes ____ No _____	Yes ____ No _____ Caregiver Initials _____