

NJDOH COVID-19 Fever and Symptom Monitoring Log for Healthcare Personnel

Day	Date	Time	Temperature
1	____/____ MONTH DAY	_____ AM	_____ °F
		_____ PM	_____ °F
2	____/____ MONTH DAY	_____ AM	_____ °F
		_____ PM	_____ °F
3	____/____ MONTH DAY	_____ AM	_____ °F
		_____ PM	_____ °F
4	____/____ MONTH DAY	_____ AM	_____ °F
		_____ PM	_____ °F
5	____/____ MONTH DAY	_____ AM	_____ °F
		_____ PM	_____ °F
6	____/____ MONTH DAY	_____ AM	_____ °F
		_____ PM	_____ °F
7	____/____ MONTH DAY	_____ AM	_____ °F
		_____ PM	_____ °F
8	____/____ MONTH DAY	_____ AM	_____ °F
		_____ PM	_____ °F

Symptom Monitoring							
Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Difficulty-Breathing	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Headache	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Sore Throat	<input type="checkbox"/> Yes	<input type="checkbox"/> No			Muscle-Ache	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Vomiting	<input type="checkbox"/> Yes	<input type="checkbox"/> No				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diarrhea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Difficulty-Breathing			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Headache		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No			Muscle-Ache	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sore Throat	<input type="checkbox"/> Yes	<input type="checkbox"/> No				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Vomiting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Difficulty-Breathing			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diarrhea	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Headache		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No			Muscle-Ache	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sore Throat	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Difficulty-Breathing			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Vomiting	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Headache		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diarrhea	<input type="checkbox"/> Yes	<input type="checkbox"/> No			Muscle-Ache	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Difficulty-Breathing			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sore Throat	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Headache		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Vomiting	<input type="checkbox"/> Yes	<input type="checkbox"/> No			Muscle-Ache	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diarrhea	<input type="checkbox"/> Yes	<input type="checkbox"/> No				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Difficulty-Breathing			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Headache		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sore Throat	<input type="checkbox"/> Yes	<input type="checkbox"/> No			Muscle-Ache	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Vomiting	<input type="checkbox"/> Yes	<input type="checkbox"/> No				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diarrhea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Difficulty-Breathing			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Headache		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No			Muscle-Ache	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sore Throat	<input type="checkbox"/> Yes	<input type="checkbox"/> No				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Vomiting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Difficulty-Breathing			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diarrhea	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Headache		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No			Muscle-Ache	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sore Throat	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Difficulty-Breathing			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Vomiting	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Headache		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diarrhea	<input type="checkbox"/> Yes	<input type="checkbox"/> No			Muscle-Ache	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No				<input type="checkbox"/> Yes	<input type="checkbox"/> No

Day	Date	Time	Temperature
9	____/____/____ MONTH DAY	_____ AM	_____ °F
		_____ PM	_____ °F
10	____/____/____ MONTH DAY	_____ AM	_____ °F
		_____ PM	_____ °F
11	____/____/____ MONTH DAY	_____ AM	_____ °F
		_____ PM	_____ °F
12	____/____/____ MONTH DAY	_____ AM	_____ °F
		_____ PM	_____ °F
13	____/____/____ MONTH DAY	_____ AM	_____ °F
		_____ PM	_____ °F
14	____/____/____ MONTH DAY	_____ AM	_____ °F
		_____ PM	_____ °F

Symptom Monitoring						
Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty-Breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No		Headache	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Sore Throat	<input type="checkbox"/> Yes <input type="checkbox"/> No			Muscle-Ache	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No				Difficulty-Breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No					Headache
Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Muscle-Ache				
Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No		Difficulty-Breathing			
Sore Throat	<input type="checkbox"/> Yes <input type="checkbox"/> No			Headache		
Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No				Muscle-Ache	
Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No					Difficulty-Breathing
Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headache				
Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No		Muscle-Ache			
Sore Throat	<input type="checkbox"/> Yes <input type="checkbox"/> No			Difficulty-Breathing		
Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No				Headache	
Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No					Muscle-Ache
Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty-Breathing				
Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No		Headache			
Sore Throat	<input type="checkbox"/> Yes <input type="checkbox"/> No			Muscle-Ache		
Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No				Difficulty-Breathing	
Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No					Headache
Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Muscle-Ache				

(1) Name: _____ Age (yrs): _____ Sex: M F

(2) Street address: _____ City, State: _____ Telephone number: _____

(3) Exposure Level (High or Medium) _____ Furloughed from work? _____

(4) Case ID number (from contact listing form): _____ Contact number (from contact listing form): _____

(5) Facility where the contact occurred case occur: _____
Date of last contact with the case (mm/dd/yyyy): _____