Highland Rim Head Start COVID-19 Monitoring Form

Printed Name	Date	Time	Fever 100.4 or higher	Cough	Sore Throat	Shortness of Breath	Close Contact, or cared for someone with COVID-19
			Yes | No	Yes | No	Yes | No	Yes | No	Yes | No
			Yes | No	Yes | No	Yes | No	Yes | No	Yes | No
			Yes | No	Yes | No	Yes | No	Yes | No	Yes | No
			Yes | No	Yes | No	Yes | No	Yes | No	Yes | No
			Yes | No	Yes | No	Yes | No	Yes | No	Yes | No
			Yes | No	Yes | No	Yes | No	Yes | No	Yes | No
			Yes | No	Yes | No	Yes | No	Yes | No	Yes | No
			Yes | No	Yes | No	Yes | No	Yes | No	Yes | No
			Yes | No	Yes | No	Yes | No	Yes | No	Yes | No
			Yes | No	Yes | No	Yes | No	Yes | No	Yes | No
			Yes | No	Yes | No	Yes | No	Yes | No	Yes | No
			Yes | No	Yes | No	Yes | No	Yes | No	Yes | No
			Yes | No	Yes | No	Yes | No	Yes | No	Yes | No
			Yes | No	Yes | No	Yes | No	Yes | No	Yes | No
			Yes | No	Yes | No	Yes | No	Yes | No	Yes | No
			Yes | No	Yes | No	Yes | No	Yes | No	Yes | No
			Yes | No	Yes | No	Yes | No	Yes | No	Yes | No
			Yes | No	Yes | No	Yes | No	Yes | No	Yes | No
			Yes | No	Yes | No	Yes | No	Yes | No	Yes | No
			Yes | No	Yes | No	Yes | No	Yes | No	Yes | No
			Yes | No	Yes | No	Yes | No	Yes | No	Yes | No
			Yes | No	Yes | No	Yes | No	Yes | No	Yes | No
			Yes | No	Yes | No	Yes | No	Yes | No	Yes | No
			Yes | No	Yes | No	Yes | No	Yes | No	Yes | No
			Yes | No	Yes | No	Yes | No	Yes | No	Yes | No
			Yes | No	Yes | No	Yes | No	Yes | No	Yes | No
			Yes | No	Yes | No	Yes | No	Yes | No	Yes | No
			Yes | No	Yes | No	Yes | No	Yes | No	Yes | No
			Yes | No	Yes | No	Yes | No	Yes | No	Yes | No
			Yes | No	Yes | No	Yes | No	Yes | No	Yes | No
			Yes | No	Yes | No	Yes | No	Yes | No	Yes | No
			Yes | No	Yes | No	Yes | No	Yes | No	Yes | No
			Yes | No	Yes | No	Yes | No	Yes | No	Yes | No
			Yes | No	Yes | No	Yes | No	Yes | No	Yes | No

Staff Signature _____ Date_____

Staff Signature _____ Date_____

* Due to HIPPA, This form is confidential information and **MUST ONLY** be viewed by Highland Rim Staff!

Return to Health Services Manager Weekly!