

Infectious Disease – Coronavirus Symptom Self-Monitoring Form Occupational Health Services

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	MPLOYEE DETAILS Name: Position:														
Date of Birth:								Visitor (Yes / No):							
Employee ID:								Contact Telephone #:							
Department:								Email:							
SIGNS & SYMPTOMS															
Please c	omplete ea	ch line	e of th	e symp	tom o	colum	ıns, tv	wice a	a day	until	the s	elf-m	onito	ring end date is reached. Temperature	
	 must be assessed twice a day. If new symptoms arise, consult with your primary care provider for care as needed and call the UCSF COVID Hotline (415.514.7328) for triage, testing recommendations, or return to work guidance. 														
(415.514	1.7328) for t	riage,	testir	ng recor	nmer	datio	ns, o	r retu	rn to	work	guida	ance.			
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Date/Time	Femperature (twice daily)	Cough	Sore Throat	Shortness of breath or difficulty breathing	Unexplained muscle	Loss of smell or taste	Nasal congestion	Diarrhea	Eye redness+/- discharge	Myalgia / Malaise	Headache	Rash	Unexplained Bleeding/		
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Signature:								Date	ਰ. <u> </u>						
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