

# East Central Illinois EMS



## Symptom Monitoring Form

Signs and Symptoms: Indicate Y or N for all symptoms.	Date:		Date:		Date:		Date:		Date:	
Record Temperature each time.	am	pm	am	pm	am	pm	am	pm	am	pm
New or worsening cough-not related to allergies										
Shortness of breath-not related to allergies										
Diarrhea										
Sore Throat-not related to allergies										
Chills or Fever										
Nausea or Vomiting										
Muscle Pain										
New loss of taste or smell										
Headache										
Fatigue										

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**Name:** \_\_\_\_\_ **Monitoring Start Date:** \_\_\_\_\_ **Monitoring End Date:** \_\_\_\_\_  
**Date of Birth:** \_\_\_\_\_ **First Date Off:** \_\_\_\_\_ **Return to Work Date:** \_\_\_\_\_

**Providers:** Record your temperature each time you take it, and for other symptoms, indicate "Y" or "N". Submit updated log to your leader or their designee no later than 9 p.m. each day.  
**Coordinators:** When your Provider has completed their Symptom Monitoring Log please keep the original copy and send a copy to [shelley.s.peelman@osfhealthcare.org](mailto:shelley.s.peelman@osfhealthcare.org)  
 Use "COVID-19 Provider Monitoring" in the email subject line.

