

Daily Self-Check

please print daily for everybody

Date: _____

AM Temp: _____

PM Temp: _____

Unusual Feeling or Symptoms:

Bowel Movement: _____ times Anything unusual? _____

COVID- 19 Early Detection Checklist:

- | | |
|--|------------------------------------|
| <input type="checkbox"/> sore throat | <input type="checkbox"/> diarrhea |
| <input type="checkbox"/> fever | <input type="checkbox"/> weakness |
| <input type="checkbox"/> cough | <input type="checkbox"/> aches and |
| <input type="checkbox"/> difficulty of breathing | <input type="checkbox"/> pains |
| <input type="checkbox"/> loss of taste | <input type="checkbox"/> |
| <input type="checkbox"/> loss of smell | <input type="checkbox"/> |

Health Maintenance

Time you Woke
up: _____

Bedtime: _____

water intake

(encircle or color the glass everytime you dink water)



MEAL

TIME

Breakfast

Lunch

Dinner

EXCERCISE

VITAMINS

- _____
- _____
- _____

HYGIENE CHECK

- Brush Teeth (AM)
- Shower
- Brush Hair
- Change Clothes
- Apply Lotion
- Bush Teeth Evening

- Trim Nails
- Clean Outer Ear
- Deodorant(for teens)
- Brush Teeth (Night)
- _____
- _____