**Name of Child Care** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Page** \_\_\_\_\_ **of** \_\_\_\_\_

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|  | **Demographics** | **Symptoms** |
| Case # (sequentially) | Name(LAST NAME, first name) | Sex (M/F/X) | Date of Birth (YYYY/MM/DD) | Room/Cohort assigned | Onset date of first symptom (yyyy/mm/dd) | Fever/chills | New or worsening cough | Shortness of breath | Sore throat | Difficulty swallowing | Cannot smell or taste | Fatigue/muscle aches | Altered mental status | Unexplained/Prolonged Headaches | Vomiting/diarrhea/abdominal pain | Runny nose, congestion (in absence of seasonal allergies) | Staff recommended that testing be completed  (Yes /No/ TBC)  | Comments | Last day of work(YYYY/MM/DD) | Date returned(YYYY/MM/DD) |
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