Health Observation Check sheet

Name: _____

Date: _____

Please answer the following questions:	No	Yes
1) Have you been infected with COVID-19 or any other acute respiratory infectious diseases within the past week?	□	□
2) Have you had any of the following symptoms within the past week (including the present)?	□	□
Fever of 37.5℃ or higher	□	□
Runny nose, cough, sore throat, or trouble breathing	□	□
Vomiting or diarrhea	□	□