　Checklist 　＊ If you visit a hospital, please bring this form.

**Student ID no./ Employee ID no. ( )　 Faculty/ Department ( )　 Name ( )**

Check your body temperature twice a day and circle your answer of the following symptoms. 1st week ・ 2nd week

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Date | / ( ) | / ( ) | / ( ) | / ( ) | / ( ) | / ( ) | / ( ) |
| AM | Body temperature | ℃ | ℃ | ℃ | ℃ | ℃ | ℃ | ℃ |
| Cough | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No |
| Shortness of breath | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No |
| Sputum | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No |
| Sore throat | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No |
| Runny nose | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No |
| Muscle aches | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No |
| Head aches | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No |
| Diarrhoea / Nausea | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No |
|  | Date | / ( ) | / ( ) | / ( ) | / ( ) | / ( ) | / ( ) | / ( ) |
| PM | Body temperature | ℃ | ℃ | ℃ | ℃ | ℃ | ℃ | ℃ |
| Cough | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No |
| Shortness of breath | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No |
| Sputum | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No |
| Sore throat | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No |
| Runny nose | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No |
| Muscle aches | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No |
| Head aches | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No |
| Diarrhoea / Nausea | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No |

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