Providence School
COVID-19 Record

Name					Student: Y/N	Staff: Y/N
Exposure Date					Symptoms Date	
Test Date			Positive	Negative	Return Date	
	Date	Time	Temperature	Cough	Shortness of Breath or difficulty breathing Y/N	Other Symptoms including: chills, fatigue, muscle or body aches, new loss of taste or smell, sore throat, congestion or runny nose, nausea, vomiting, or diarrhea
Day 0	Day of Exposure, symptoms, or positive test					
Day 1 AM						
Day 1 PM						
Day 2 AM						
Day 2 PM						
Day 3 AM						
Day 3 PM						
Day 4 AM						
Day 4 PM						
Day 5 AM						
Day 5 PM						
Day 6 AM						
Day 6 PM						
Day 7 AM						
Day 7 PM						
Day 8 AM						

Day 8 PM						
Day 9 AM						
Day 9 PM						
Day 10 AM						
Day 10 PM						
Day 11 AM						
Day 11 PM						
Day 12 AM						
Day 12 PM						
Day 13 AM						
Day 13 PM						
Day 14 AM						
Day 14 PM						
Signature of Student/Staff Member						
Signature of Providence School Nurse						