

Health Observation Card [Children/Staff]

Please put ✓ where it applies. Other symptoms, such as absent-minded, bad mood, lack of appetite, please write in "Other."

Please fill this out every day, including days you have do not go to the school.

Class : _____

Name : _____

Symptoms		Example	/ (M)	/ (T)	/ (W)	/ (Th)	/ (F)	/ (Sa)	/ (Su)
Children / Staff	Body Temp.	AM 36.5°C	°C	°C	°C	°C	°C	°C	°C
		PM 37.0°C	°C	°C	°C	°C	°C	°C	°C
	Cough	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y
	Runny nose	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y
	Sore throat	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y
	Vomiting · Diarrhea	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y
	Abnormality in sense of taste and smell	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y
	Other	Bad mood							
	Possibility of contact with infected person	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y
	Person living together	Physical condition	<input type="checkbox"/> Everyone well <input type="checkbox"/> Other <input type="checkbox"/> Other	<input type="checkbox"/> Everyone well <input type="checkbox"/> Other	<input type="checkbox"/> Everyone well <input type="checkbox"/> Other	<input type="checkbox"/> Everyone well <input type="checkbox"/> Other	<input type="checkbox"/> Everyone well <input type="checkbox"/> Other	<input type="checkbox"/> Everyone well <input type="checkbox"/> Other	<input type="checkbox"/> Everyone well <input type="checkbox"/> Other
Other		Father 37.5°C							
Possibility of contact with infected person		<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y
Confirmation from school									

★ "Been labelled as close-contact person" "Co-worker caught the virus···!" Let school know immediately!

Health Observation Card [Person living together]

Please put ✓ where it applies. Other symptoms, such as loss of appetite, please write in "Other." Name :

Symptoms		Example	/ (M)	/ (T)	/ (W)	/ (Th)	/ (F)	/ (Sa)	/ (Su)
Your physical condition	Body Temp	AM 36.5°C	°C	°C	°C	°C	°C	°C	°C
		PM 36.8°C	°C	°C	°C	°C	°C	°C	°C
	Cough	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y
	Runny nose	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y
	Sore throat	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y
	Vomiting	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y
	Diarrhea	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y
	Abnormality in sense of taste and smell	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y
	Other	Loss of appetite							
	Possibility of contact with infected person	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y

★“Been labelled as close-contact person” “Co-worker caught the virus…!” Let school know immediately!