Health Monitor Check-in

PROOF OF VACCINATION

First Name:_____

Last Name: _____

Photo ID: Type, e.g., driver's license, passport: _____

ID # (and state): _____

CDC COVID-19 Vaccination Record Card:

Verify name matches photo government ID: ___yes ___no

Vaccine Dosage (circle one): ___one dose ___two doses

Vaccine Product Name/Manufacturer:

1st dose: Date: _____
Vaccine Product Name/Manufacturer: (circle): J&J, Janssen, Moderna, Pfizer-BioNTech
Healthcare Professional or Clinic Site: _____

2nd dose: Date: _____
Vaccine Product Name/Manufacturer: (circle): J&J, Janssen, Moderna, Pfizer-BioNTech
Healthcare Professional or Clinic Site: _____

PROOF NEGATIVE COVID-19 TEST

_____**Check if the name matches photo ID**

Verify negative test taken (circle one)
_____Negative COVID-19 PCR test within 72 hrs. prior
_____Negative COVID-19 Rapid Antigen Test within 24 hrs. prior

Provider, laboratory, or patient platform for healthcare provider: _____
(e.g., Healthvana, CommonPass, CLEAR Health Pass)

Collected Date: _____ Reported Date: _____

Date: _____

DAILY HEALTH MONITOR QUESTIONS

	CIRCLE
In the past 10 days have you experienced any of the following new or worsening symptoms? • Fever • Shortness of breath or difficulty breath • Sinus congestion or runny nose • Loss of taste or smell • Persistent cough	**YES NO**
In the past 10 days have you experienced any of the following new or worsening symptoms? • Nausea, vomiting, diarrhea or loss of appetite • Headaches or sore throat • Severe muscle aches • Fatigue	**YES NO**
In the past 14 days have you been diagnosed with COVID-19 or asked to quarantine?	**YES NO**
In the past 10 days have you been asked to get a COVID-19 test due to symptoms or Risk of exposure and are still waiting for the results or received an inconclusive result?	**YES NO**