



COVID -19 SYMPTOM TRACKER

Please fill this out and bring to your YouthWorks trip. You will also use this document to track symptoms during your trip.

Name:

Church/Group:

Trip Start Date:

Safety has always been a top priority for YouthWorks. Because of COVID-19, we're taking extra steps to make sure participants arrive healthy to their mission trip site. One of those steps is to track symptoms leading up to the trip, as well as during the trip. We encourage you to look at this safety measure as a way to care for each other and communities.

For your safety, participants will not be allowed to attend if they are currently sick with COVID-19 symptoms, if they have had one "more common" or two or more "less common" COVID-19 symptoms in the last 10 days or if they have been around someone with COVID-19 in the last 14 days. If a participant experiences one "more common" or two or more "less common" COVID-19 symptoms leading up to the trip and believes their symptoms are not COVID-related, they would need to have a negative COVID-19 test and be cleared by a medical professional before being able to arrive on site.

Instructions: Please thoroughly and honestly fill out this symptom tracker daily for the 10 days leading up to the trip start date (usually a Sunday). Please review the list of symptoms below, as well as the definition of "close contact." Don't forget to fill out the Name, Church/Group and Trip Start Date box in the upper right corner. Be prepared for your Adult Leaders and/or YouthWorks staff to view this tracker before you leave for your trip and throughout the trip.

Note: A **close contact** is defined by the CDC as being "within 6 feet of an infected person for a total of 15 minutes or more. An infected person can spread COVID-19 starting from 48 hours (or 2 days) before the person has any symptoms or tests positive for COVID-19."

Days 14-11 before your trip: Have you been in close contact with anyone who has a confirmed case of COVID-19? Yes No

	Ten Days before your Trip Start Date	Nine Days before your Trip Start Date	Eight Days before your Trip Start Date	Seven Days before your Trip Start Date	Six Days before your Trip Start Date
	Date:	Date:	Date:	Date:	Date:
Have you experienced any of the more common COVID-19 Symptoms? (<i>fever of 100.4 degrees F or higher, new cough or cough that gets worse, difficulty breathing, new loss of taste or smell</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No Temp (choose one): <input type="checkbox"/> Below 98.6 <input type="checkbox"/> 98.6-100.3 <input type="checkbox"/> 100.4 or above	<input type="checkbox"/> Yes <input type="checkbox"/> No Temp (choose one): <input type="checkbox"/> Below 98.6 <input type="checkbox"/> 98.6-100.3 <input type="checkbox"/> 100.4 or above	<input type="checkbox"/> Yes <input type="checkbox"/> No Temp (choose one): <input type="checkbox"/> Below 98.6 <input type="checkbox"/> 98.6-100.3 <input type="checkbox"/> 100.4 or above	<input type="checkbox"/> Yes <input type="checkbox"/> No Temp (choose one): <input type="checkbox"/> Below 98.6 <input type="checkbox"/> 98.6-100.3 <input type="checkbox"/> 100.4 or above	<input type="checkbox"/> Yes <input type="checkbox"/> No Temp (choose one): <input type="checkbox"/> Below 98.6 <input type="checkbox"/> 98.6-100.3 <input type="checkbox"/> 100.4 or above
Have you experienced two or more of the less common COVID-19 Symptoms? (<i>sore throat, vomiting, diarrhea, chills, muscle pain, extreme fatigue, new severe headache, new nasal congestion/stuffy/runny nose</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been in close contact with anyone who has a confirmed case of COVID-19?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

	Five Days before your Trip Start Date	Four Days before your Trip Start Date	Three Days before your Trip Start Date	Two Days before your Trip Start Date	One Day before your Trip Start Date
	Date:	Date:	Date:	Date:	Date:
Have you experienced any of the more common COVID-19 Symptoms? (<i>fever of 100.4 degrees F or higher, new cough or cough that gets worse, difficulty breathing, new loss of taste or smell</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No Temp (choose one): <input type="checkbox"/> Below 98.6 <input type="checkbox"/> 98.6-100.3 <input type="checkbox"/> 100.4 or above	<input type="checkbox"/> Yes <input type="checkbox"/> No Temp (choose one): <input type="checkbox"/> Below 98.6 <input type="checkbox"/> 98.6-100.3 <input type="checkbox"/> 100.4 or above	<input type="checkbox"/> Yes <input type="checkbox"/> No Temp (choose one): <input type="checkbox"/> Below 98.6 <input type="checkbox"/> 98.6-100.3 <input type="checkbox"/> 100.4 or above	<input type="checkbox"/> Yes <input type="checkbox"/> No Temp (choose one): <input type="checkbox"/> Below 98.6 <input type="checkbox"/> 98.6-100.3 <input type="checkbox"/> 100.4 or above	<input type="checkbox"/> Yes <input type="checkbox"/> No Temp (choose one): <input type="checkbox"/> Below 98.6 <input type="checkbox"/> 98.6-100.3 <input type="checkbox"/> 100.4 or above
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Have you been in close contact with anyone who has a confirmed case of COVID-19?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

On Your Trip

	Trip Start Date Typically a Sunday	Day One Typically a Monday	Day Two Typically a Tuesday	Day Three Typically a Wednesday	Day Four Typically a Thursday	Day Five Typically a Friday
	Date:	Date:	Date:	Date:	Date:	Date:
Have you experienced any of the more common COVID-19 Symptoms? (<i>fever of 100.4 degrees F or higher, new cough or cough that gets worse, difficulty breathing, new loss of taste or smell</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No Temp (choose one): <input type="checkbox"/> Below 98.6 <input type="checkbox"/> 98.6-100.3 <input type="checkbox"/> 100.4 or above	<input type="checkbox"/> Yes <input type="checkbox"/> No Temp (choose one): <input type="checkbox"/> Below 98.6 <input type="checkbox"/> 98.6-100.3 <input type="checkbox"/> 100.4 or above	<input type="checkbox"/> Yes <input type="checkbox"/> No Temp (choose one): <input type="checkbox"/> Below 98.6 <input type="checkbox"/> 98.6-100.3 <input type="checkbox"/> 100.4 or above	<input type="checkbox"/> Yes <input type="checkbox"/> No Temp (choose one): <input type="checkbox"/> Below 98.6 <input type="checkbox"/> 98.6-100.3 <input type="checkbox"/> 100.4 or above	<input type="checkbox"/> Yes <input type="checkbox"/> No Temp (choose one): <input type="checkbox"/> Below 98.6 <input type="checkbox"/> 98.6-100.3 <input type="checkbox"/> 100.4 or above	<input type="checkbox"/> Yes <input type="checkbox"/> No Temp (choose one): <input type="checkbox"/> Below 98.6 <input type="checkbox"/> 98.6-100.3 <input type="checkbox"/> 100.4 or above
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Have you been in close contact with anyone who has a confirmed case of COVID-19?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No