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EBOLA VIRUS DISEASE DAILY CONTACT MONITORING FORM

Last Name:_____ First Name:_____ Date of Birth(yyyy/mm/dd): _____

Incubation period start (yyyy/mm/dd) _____ Incubation period end (yyyy/mm/dd) _____

Number of days since start of incubation period	Follow-up Date	Temperature Recording		Symptoms (check all that apply)	Comments/Action Items	Person completing assessment
		Check 1/AM	Check 2/PM			
				☐ Fever ☐ Chills ☐ Rash ☐ Nausea ☐ Headache ☐ Diarrhea ☐ Muscle pain ☐ Vomiting ☐ Sore throat ☐ Haemorrhaging ☐ Conjunctivitis ☐ Other, specify: _____ ☐ None	☐ Unable to contact Medications taken: Concern of non-compliance ☐ yes ☐ no Specify: ☐ referred to MHO and self-isolate due to symptoms ☐ specimen collected Notes:	

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