Daily diary log

Last Name: **First Name:**

Start Date DD-MM-YYYY:

Please check the box below if you experienced any of the following symptoms

If you become symptomatic, please seek medical attention and notify your care provider that you have potentially been exposed to A(H5N1).

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9	Day 10	Day 11	Day 12	Day 13	Day 14	Day 15	Day 16	Day 17	Day 18	Day 19	Day 20	Day 21
Presence on farm																					
Amount of time on farm (specify in hours)																					
Fever ≥38°C (measured)																					
Feverish/ chills (temp not taken)																					
Fatigue																					
Muscle pain																					
Joint pain																					
Headache																					
Cough																					
Sore throat																					
Runny nose																					
Difficulty breathing or Shortness of breath																					
Red or watery eyes																					
Discharge from eyes																					
Diarrhea																					
Vomiting																					
Nausea																					
Seizures																					
Other sign or symptom _____																					