

Self-Monitoring Sheet

<Update 2022.4>

Name:	Affiliation:	Place of residence: (Name of municipality)
Student ID:	Age:	Contact:
Vaccination status of covid-19 : <input type="checkbox"/> once <input type="checkbox"/> twice <input type="checkbox"/> 3times <input type="checkbox"/> Not vaccinated		
PCR test for covid-19 : <input type="checkbox"/> No <input type="checkbox"/> Completed (Date: /)Result: <input type="checkbox"/> positive <input type="checkbox"/> negative		
Antigen test for covid-19: <input type="checkbox"/> No <input type="checkbox"/> Completed (Date: /)Result: <input type="checkbox"/> positive <input type="checkbox"/> negative		

Day/Month		/	/	/	/	/
Body Temperature	Morning	()°C	()°C	()°C	()°C	()°C
	Night	()°C	()°C	()°C	()°C	()°C
Symptoms	Cough	<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
	Sore throat	<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
	Strong Sluggishness	<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
	Breathlessness	<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
	Taken medicines	<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
	Other symptoms (State details if "Yes")	<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
Day/Month		/	/	/	/	/
Body Temperature	Morning	()°C	()°C	()°C	()°C	()°C
	Night	()°C	()°C	()°C	()°C	()°C
Symptoms	Cough	<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
	Sore throat	<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
	Strong Sluggishness	<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
	Breathlessness	<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
	Taken medicines	<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
	Other symptoms (State details if "Yes")	<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
Day/Month		/	/	/	/	/
Body Temperature	Morning	()°C	()°C	()°C	()°C	()°C
	Night	()°C	()°C	()°C	()°C	()°C
Symptoms	Cough	<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
	Sore throat	<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
	Strong Sluggishness	<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
	Breathlessness	<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
	Taken medicines	<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
	Other symptoms (State details if "Yes")	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" 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

If you are under the condition ①-⑤, consult by phone with either of the institutions on the right (1-2).

- ① Fever (37.5°C or higher or 1.0°C higher than normal fever)
- ② Cold symptoms (cough, sore throat, runny nose, nasal congestion, general malaise, general muscle and joint pain, headache, etc.)
- ③ Gastrointestinal symptoms (persistent diarrhea, nausea and vomiting, abdominal pain, loss of appetite)
- ④ Taste and smell disorders ⑤Breathlessness

- 1. Call your family doctor.
- 2. If you can't do 1, call consultation with Fukuoka International Medical Support Center
TEL:092-286-9595 (24 hours a day)

**E-mail this Sheet to
Consultation services**

Tobata campus
lizuka campus
Wakamatsu campus

t.COVID-19.stu@jimu.kyutech.ac.jp
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w.COVID-19.stu@jimu.kyutech.ac.jp