DAILY HEALTH SCREENING

* indicates a required field

DAILY STUDENT SCREENING

Complete and submit this form by 9:00 AM each day.

Today's Date: *

Did you take your child's temperature today?: *
◯ Yes ◯ No

Does you child have a fever of 100.4 and above?: *
◯ Yes ◯ No

Does your child show signs of fatigue?: *
◯ Yes ◯ No

Does your child have a headache?: *
◯ Yes ◯ No

Does your child have a sore throat?: *
◯ Yes ◯ No

Does your child have a cough?: *
◯ Yes ◯ No

Does your child have diarrhea?: *
◯ Yes ◯ No

I am following CDC guidelines limiting child's exposure to risks above.: *
◯ Yes ◯ No

Parent Name Completing Form: *

Has your child traveled to a "Hot Spot" location?: *
◯ Yes ◯ No

Does your child have fever or chills?: *
◯ Yes ◯ No

Does your child have shortness of breath or difficulty breathing?: *
◯ Yes ◯ No

Does your child have muscle or body aches?: *
◯ Yes ◯ No

Has your child experienced a new loss of taste or smell?: *
◯ Yes ◯ No

Does your child have congestion or a runny nose?: *
◯ Yes ◯ No

Is your child experiencing nausea or vomiting?: *
◯ Yes ◯ No

Has you child had any contact with anyone with Covid: *
◯ Yes ◯ No

Child Name:: *