COVID-19 Student Daily Health-Screening Questionnaire

Please complete the following questionnaire in the morning before school and send the document with your child to school on Tuesday (green group) or Thursday (white group) each week.

STUDENT Name: ____

PARENT/GUARDIAN Name: ____

Date: ____________________

Questions	*Please Check One*	
	Yes	**No**
1. Have you or a member of your household tested positive for, or had a confirmed case of COVID-19 in the past 14 days?	❑	❑
2. Are you experiencing any COVID-19 or flu-like symptoms such as (Fever or chills, Cough, Shortness of breath or difficulty breathing, Fatigue, Muscle or body aches, Headache, New loss of taste or smell, Sore throat, Congestion or runny nose, Nausea or vomiting, Diarrhea?) *Check "No" if	❑	❑
3. Are you or any member of your household under active quarantine due to COVID-19 exposure?	❑	❑
4. Have you been in contact with anyone who has a confirmed case of, or has been exposed to COVID-19?	❑	❑
5. Have you traveled outside the U.S. within the past 14 days or to any of the current restricted states?	❑	❑

If you have answered "YES" to any questions above (1-5) please:

- ***Do not place your child on the bus***
- ***Do not enter any school buildings***
- ***Immediately notify your child's teacher or School Nurse***

❑ **I have reviewed and answered to the best of my knowledge "NO" to all of the questions above.**

❑ **I understand if at any time if my symptoms change, I will immediately notify an administrator.**

Parent Signature:____ **Date:**___________________