COVID-19 SCREENING FORM for STUDENTS

Please complete this form to assess your potential exposure to or diagnosis of COVID-19 or other illnesses. If you answered Yes to any of these questions, please do not enter our building.

Turn this sheet into the building office professional.

Student Name (print):_____ Date:_____

Building Location:_____

Best Contact Phone Number for today:_____

Questions	YES	NO
Do you have any of the following symptoms within the last day that are not caused by another condition?		
• Fever (100.4° F) or chills		
• Cough		
• Shortness of breath or difficulty breathing		
• New loss of taste or smell		
• Congestion or runny nose		
• Chest pain, pressure, or tightness		
• Fatigue or difficulty with exercise		
• Headache		
• Persistent muscle aches or pains		
• Sore Throat		
• Nausea or vomiting		
• Diarrhea		
Has your student taken any medication to reduce a fever before coming to school today?		

Within the last 10 days, have you or a household member

- been identified as a close contact to a person with confirmed COVID-19 or
- had a positive COVID-19 test for active virus or are awaiting results of a COVID-19 test or
- within the past 14 days, has a public health or medical professional told you to self-monitor, self-isolate, or self-quarantine because of concerns about COVID-19 infection?

( ) YES ( ) NO DATE OF TEST:___/___/___

Signature:_____ Date: _____

Updated: 2/25/2021