

# COVID 19 Health Screening for In-Person School

*Parents or Guardians: This form must be completed for **each child** and for **each day** that your child plans to attend school or enter a school building for in-person services. This form must come to school with your child as they enter the bus or a school building, if they walk or you are dropping them off.*

Student's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Parent Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

School: \_\_\_\_\_

How are you feeling today? (Circle one)      Well                      Not well

**Do you have ANY of the following symptoms (circle or check as appropriate):**

- A fever of 100.0°F or higher, or a sense of having a fever
- Chills
- A cough
- Shortness of breath or difficulty breathing
- Unusual fatigue
- Muscle or body aches
- Headache
- Recent loss of taste or smell
- A sore throat
- Congestion/runny nose
- Nausea or vomiting
- Diarrhea
  
- None of the above symptoms

**Have you been in close contact with anyone with confirmed COVID 19?** (circle one)      Yes      No

**Have you had a positive COVID – 19 test for active virus in the past 10 days?** (circle one)      Yes      No

**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?** (circle one)      Yes      No

**If the student has any of the above symptoms or the response is “YES” to any of these questions, the student **may not come to school or into a school** for in-person services.**

**If the student develops any of these symptoms while at school, district staff will follow our isolation protocols and contact you to pick up your child from school.**