COVID 19 Health Screening

*This form must be completed for or by **each individual** and for **each day** that the individual plans to attend school or enter a school building if for some reason the individual is unable to complete for any reason the health check or attestation electronically.*

Individual's Name: _____ Date: _____

Parent Name (if student is individual): _____ Phone #: _____

School/Facility: _____

Have you had ANY of the following symptoms in the past 24 hours that are not caused by another condition?

- o A fever of 100.0°F or higher
- o Cough
- o Shortness of breath or difficulty breathing
- o Chills
- o Fatigue
- o Muscle or body aches
- o Headache
- o Recent loss of taste or smell
- o Sore throat
- o Congestion or runny nose
- o Nausea or vomiting
- o Diarrhea

- o 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, or are you awaiting results of a COVID-19 test? (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 individual has any of the above symptoms or the response is "YES" to any of these questions, stay home and do not report to school or access the facility.

If the symptoms develop while at school or in our facility, district staff will follow our isolation protocols to help the individual who is experiencing symptoms depart from school or our facility promptly.