# Health Screening for In-Person Services

*This form is used for students entering the school building for in-person services. Please have a trained staff member ask the parent (preschool and elementary) or the student (secondary) these questions, record the answers and then escort the student to the testing location.*

Student's Name: _____ Date: _____

Time: _____

Staff member recording responses: _____ School: _____

Parent Name: _____ Phone #: _____

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

Temperature Scan: (Circle one) Less than 100 100 degrees or more

***Proceed only if temperature is under 100 degrees***

**Do you have ANY of the following symptoms:**

- A fever of 100.0°F or higher
- Chills
- A cough
- Shortness of breath or difficulty breathing
- or a sense of having a fever
- Unusual fatigue
- Muscle or body aches
- Headache
- Recent loss of taste or smell
- A sore throat
- Nausea or vomiting
- Congestion/runny nose
- Diarrhea

**Have you been in close contact with anyone with confirmed COVID 19?** Yes No

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

**If YES to any of these questions, the student may not come into school or be tested.**

Revised 9/2020