John Burroughs School COVID-19 Screening Form

Date: _____

Student's First Name: _____ Student's Last Name:_____

Grade _____

1. Do you currently or have you had a fever of 100.4 or above in the past 14 days?

   Yes _____ No _____

2. Have you been in close contact (less than 6 feet for 15 minutes) with someone who has been diagnosed with COVID or has had COVID symptoms in the past 14 days?

   Yes _____ No _____

3. Are you currently awaiting the results of a COVID test that you took due to symptoms and/or close contact with a COVID positive individual?

   Yes _____ No _____

4. Are you experiencing any of the following symptoms not explained by another known condition?

   _____ Cough

   _____ Shortness of Breath or Difficulty Breathing

   _____ Fatigue, Muscle or Body Aches

   _____ Headache

   _____ Sore Throat

   _____ Congestion or Runny Nose

   _____ Loss of Taste or Smell

   _____ Nausea, Diarrhea, Vomiting

   _____ I have none of the above symptoms