MALDEN CATHOLIC HIGH SCHOOL

COVID-19 DAILY PRE-SCREENING QUESTIONS

Name of Student: _____ Date: _____

Parent/Guardian Cell: _____ Sport: _____

Are you experiencing any of the following symptoms?	**Please Circle One**	
1. Fever (≥ 99.5)	YES	NO
2. Cough or shortness of breath	YES	NO
3. Sore Throat	YES	NO
4. Chills	YES	NO
5. Muscle aches or rigors	YES	NO
6. Headache	YES	NO
7. New loss of taste or smell	YES	NO
8. Abdominal pain, nausea, vomiting or diarrhea	YES	NO
Have you had close contact with someone who is currently sick?	YES	NO
Have you been diagnosed with COVID-19 in the past three weeks or have reason to believe you have COVID-19?	YES	NO
Have you traveled or had close contact with anyone who has traveled internationally in the last 14 days?	YES	NO

If you took your temperature this morning, what was the reading? _____

*Definition of Close Contact : contact with anyone for more than 15 minutes and less than 6 feet apart.