Date: _____

Student's Name _____

Temperature _____ degrees Fahrenheit

Symptoms?

Cough	Yes/No
Loss of Smell	Yes/No
Loss of Taste	Yes/No
Difficulty Breathing	Yes/No
Muscle Aches	Yes/No
Sore Throat	Yes/No
Feeling Ill	Yes/No
Headache	Yes/No
Diarrhea	Yes/No
Fatigue	Yes/No
Nausea/Vomiting	Yes/No

Exposure to known or suspected COVID case in past 72 hours Yes/No

Tested Positive for COVID 19 Yes/No date: _____

Guardian Signature _____

Guardian Name _____