



Before your child leaves for school each morning,  
please complete this health screening questionnaire.

**IF THE ANSWER TO ANY OF THE QUESTIONS BELOW IS YES  
PLEASE KEEP YOUR CHILD AT HOME AND  
CONTACT YOUR HEALTHCARE PROVIDER.**

**FOR EVERYONE'S HEALTH AND SAFETY, IT IS CRITICALLY IMPORTANT THAT YOU NOT ENTER THE BUILDING UNLESS YOU CAN ANSWER "NO" TO EACH OF THE FOLLOWING QUESTIONS:**

1. In the last 48 hours, have you experienced any of the following symptoms that you are not sure is caused by another condition that is not COVID-19 that is not contagious:  
 Fever (100.4 degrees Fahrenheit or higher) or feeling feverish (chills, sweating)  
 New cough  
 Shortness of breath or difficulty breathing  
 Muscle aches or body aches  
 New loss of taste or smell  
 Headache  
 Sore throat  
 Nausea  
 Vomiting or diarrhea  
 Fatigue  
 Congestion or runny nose
2. In the last 14 days, have you been in close contact\* with anyone that you know had COVID-19 or who had COVID-19-like symptoms?  Y  N
3. In the last ten days, have you had a positive COVID-19 test for the active virus?  Y  N
4. Are you currently waiting on the results of a COVID-19 test?  Y  N
5. In the last 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?  Y  N
6. In the last 14 days, have you traveled internationally, or been in close contact with anyone who has traveled internationally, to a country designated by the Centers for Disease Control as Warning Level 3, Avoid Nonessential Travel, due to COVID-19?  Y  N

\* For purposes of the screening, "close contact" includes being within approximately 6 feet (2 meters) of a person with confirmed or suspected COVID-19 for 15 minutes or more. It also includes caring for or having direct contact with a person with confirmed or suspected COVID-19 (e.g., kissing, hugging, touching them) or their respiratory droplets (e.g., being sneezed or coughed on by them).