Convent & Stuart Hall
Schools of the Sacred Heart San Francisco

COVID-19 Screening

Student's name: _____

Parent's name: _____

1. Have you been in contact with a person with confirmed COVID-19 within the last 14 days?

❑ Yes ❑ No

2. Have you had any one or more of these symptoms today or within the past 24 hours, which is new or not explained by another reason?:

- fever (above 100.4 F), chills
- cough
- shortness of breath or difficulty breathing
- nausea or vomiting
- sore throat
- diarrhea
- headache
- Not being able to taste or smell, or saying that things taste or smell different (within the last 10 days)

❑ Yes ❑ No

* If yes to any of the questions above *that cannot be explained by another medical condition* , do not come to campus and call your primary physician.

3. If the above symptom(s) *are* related to another medical condition, please note that condition here:_____

4. I confirm that I've taken my child/ren's temperature this morning, and the reading was afebrile._____ (please initial)

5. Please indicate your child/ren's most recent COVID-19 testing date :_____

Parent's signature: _____ Date: _____