BTMES COVID-19 Health Screening- Complete & give to school staff daily

Student Name:_______________________________________ Date:________________

Symptoms of COVID-19 include:***Fever or chills, Cough, Fatigue, Sore Throat, Muscle/Body aches, Shortness of breath or difficulty breathing, Headache-if other symptoms present, New loss of taste or smell, Congestion/Runny nose, Nausea/Vomiting, Diarrhea***

1. Does the student have any of the potential symptoms of COVID-19? Yes or No
2. Has the student been in close contact with a person positive for COVID-19 in the past 14 days? Yes or No
3. Has the student traveled out of the state of VT in the past 14 days? Yes or No
4. The student's temperature was above 100.0 degrees this morning? Yes or No

****If you answered "YES" to any question above, please keep student home and contact the school nurse for further guidance (802)477-5008****

Parent/Guardian Signature:____

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