WELLNESS SCREENING QUESTIONS

Student Name: _____

Date: _____

1. Have you experienced any of the following symptoms within the last day that are not caused by another condition or in a way not normal to you?

- Fever (100.4°F) or chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- Recent loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

☐ Yes ☐ No

2. Are any of the following statements true?

- You have been in close contact with someone with confirmed COVID-19.
- You have had a positive COVID-19 test for active virus in the past 10 days.
- You have been told by a public health or medical professional within the past 14 days to self- monitor, self-isolate, or self-quarantine because of concerns about COVID-19 infection.

☐ Yes ☐ No

If you answered **NO** to both questions, you are feeling well enough for school today.

If you answered **YES** to one or both questions, please stay home today.

Please notify your school administrator if you have COVID-19, are waiting for test results, or have been exposed to someone with a confirmed or suspected case.

Parent Signature _____

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