COVID-19 Daily Screening

Name: _____ Date: _____

Section 1: Symptoms

Any of the symptoms below could indicate a COVID-19 infection and may put you at risk for spreading illness to others. Please note that this list does not include all possible symptoms and someone with COVID-19 may experience any, all, or none of these symptoms. Please check your daily for these symptoms:

Column A	
☐	Fever (measured or subjective)
☐	Chills
☐	Rigors (shivers)
☐	Myalgia (muscle aches)
☐	Headache
☐	Sore Throat
☐	Nausea or Vomiting
☐	Diarrhea
☐	Fatigue
☐	Congestion or runny nose

Column B	
☐	Cough
☐	Shortness of Breath
☐	Difficulty Breathing
☐	New loss of smell
☐	New loss of taste

☐	**NONE FROM COLUMN A or B**

Anyone who is sick (e.g. fever, vomiting, diarrhea) should not attend school events. If TWO OR MORE of the fields in Column A are checked off OR AT LEAST ONE field in column B is checked off, please stay home and notify your doctor for further instructions.

Section 2: Close Contact/Potential Exposure

Please verify if in the last 14 days:

☐	You have had close contact (within 6 feet of an infected person for 15 or more minutes during a 24-hour period) with a person with COVID-19
☐	Someone in your household is diagnosed with or being tested for COVID-19 or experiencing symptoms.
☐	You have traveled from any U.S. State or territory outside of New York, Connecticut, Pennsylvania, and Delaware and is not otherwise exempt from quarantine under the *DOH travel restrictions*

☐	**NONE OF THE ABOVE**

If ANY of the fields in Section 2 are checked off, you should remain home for 14 days from the last date of exposure (if a close contact of a confirmed COVID-19 case) or date of return to New Jersey. Contact your local health department for further guidance.

Signature:_____ Date: _____

Temperature Check: _____