Within the past 24 hours have you had any of these symptoms?

Select the symptom(s) only if you cannot attribute them to another medical condition.


Cough


Headache


Sore Throat


Loss of Taste or Smell


Digestive Problems


Shortness of Breath


Nausea or Vomiting

Please take your temperature. In the past 24 hours, have you had a temperature over 100.0 degrees Fahrenheit?

Yes | No

In the last 10 days did you have close contact (within 6 feet for a total of 15 minutes or more in a 24 hour period) with anyone diagnosed with COVID-19 or suspected of having COVID-19?

If you are fully vaccinated (14 days after receiving your final dose), answer No.

Yes | No

Are you currently awaiting test results for a COVID-19 test that was conducted outside of routine surveillance testing required by the School?

Yes | No

In the last 10 days, have you been diagnosed with COVID-19 or been instructed by any health care provider or the health department to isolate or quarantine?

Yes | No