COVID-19 Health Screening
Daily Self-Screening Form

You must complete and submit this form each day before reporting to campus. If the answer to any of the following questions is YES, please consult your campus administration team.

Date: _____

This form applies to:

Student Name	Student Grade

In the last 14 days, has anyone in your household had close contact with someone who has or is suspected to have COVID-19?

☐ Yes ☐ No

In the last 48 hours, has your child(ren) experienced any of the following symptoms?

- Fever *(over 100.4 °F)*
- Headache
- Cough
- Sore throat
- Shortness of breath
- Chills
- Muscle aches
- Loss of taste or smell
- Gastrointestinal *(nausea, vomiting or diarrhea)*

☐ Yes ☐ No

_____ _____ _____

Your Name **Email** **Phone**

_____

Parent/Guardian Signature