COVID-19 SCREENING QUESTIONNAIRE

STUDENT NAME: _____ DATE: _____

CLASS: _____

ODY TEMPERATURE(°F): _____

(TEMPERATURE IS TAKEN AT SCHOOL)

	YES	NO
CHILLS:	☐	☐
FATIGUE:	☐	☐
MUSCLE or BODY ACHES:	☐	☐
HEADACHE:	☐	☐
RECENT LOSS OF TASTE or SMELL:	☐	☐
SORE THROAT:	☐	☐
ON and/or RUNNING NOSE (IF KNOWN ALLERGY, CHECK NO):	☐	☐
NAUSEA and/or VOMITING:	☐	☐
DIARRHEA:	☐	☐
HAVE YOU COME INTO CLOSE CONTACT (WITHIN 6 FEET) WITH SOMEONE WHO HAS A LABORATORY-CONFIRMED COVID-19 POSITIVE IN THE PAST 14 DAYS:	☐	☐

*** THIS FORM MUST BE COMPLETED, AT HOME, BEFORE ENTERING THE BUILDING.**

*** PLEASE STAY HOME FOR 14 DAYS IF ONE OR MORE ANSWERS ARE "YES".**

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