FPS COVID-19 DAILY HEALTH SCREENING

Date_____

Student Name _____ Grade/Teacher _____

Section 1:

Does child have a temperature over 100.4F? Yes/No (Without the use of fever-reducing or other symptom-altering medicines)

Does child have any of the following symptoms?

Fever or chills Yes/No Muscle or body aches Yes/No New or worsening cough Yes/No

New or worsening congestion/runny nose Yes/No New or worsening sore throat Yes/No

In the last 14 days prior, has your child had:

Shortness of breath/difficulty breathing Yes/No New loss of taste or smell Yes/No

Headache Yes/No Diarrhea Yes/No Nausea or vomiting Yes/No

Section 2:

Or has the child been in close contact with someone diagnosed with COVID-19 or placed in quarantine for possible exposure?

Yes/ No

Have you been asked to self-isolate or quarantine by a medical professional or a local public health official in the last two weeks?

Yes/No

Traveled to a place where COVID-19 is Spreading? Yes/No

_____ _____

Parent/guardian Signature Date

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