COVID-19 Student Self-Screening Form

Screen your child before leaving for school or sending them to school. If your child shows symptoms of COVID-19, do not send them to school.

Section 1: In the last 24 hours, has your child developed any of the following symptoms that are new/different/worse from baseline of any chronic illness:

Cough:	☐ Yes	☐ No
Shortness of breath:	☐ Yes	☐ No
Difficulty breathing:	☐ Yes	☐ No
New loss of smell:	☐ Yes	☐ No
New loss of taste:	☐ Yes	☐ No

Section 2: In the last 24 hours, has your child developed any of the following symptoms that are new/different/worse from baseline of any chronic illness:

Subjective fever (felt feverish) or measured temperature of 100.4°F or higher:	☐ Yes	☐ No
Chills or rigors (severe chills with shivering):	☐ Yes	☐ No
Headache:	☐ Yes	☐ No
Sore throat:	☐ Yes	☐ No
Runny nose or congestion:	☐ Yes	☐ No
Muscle aches:	☐ Yes	☐ No
Fatigue:	☐ Yes	☐ No
Nausea:	☐ Yes	☐ No
Vomiting:	☐ Yes	☐ No
Diarrhea:	☐ Yes	☐ No

If you answer **YES** to any of the symptoms listed in ***Section 1***, **OR YES** to two or more of the symptoms listed in ***Section 2***, please do not send your child to school. Self-isolate at home and contact your healthcare provider for direction and possible testing for COVID-19.

In the past 14 days, has your child:

Had close contact with an individual who has tested positive for COVID-19?	☐ Yes	☐ No

If you answer **YES** to the above question, please do not send your child to school. Self-quarantine at home for 10 days. Contact your healthcare provider if your child has symptoms.