COVID-19 Daily Screening for Students' Staff

Name _____ Date _____

Parents/Guardians: Please complete this short check **each morning** and return to school with your child. No child will enter the building without it.

Section 1: Symptoms Any of the symptoms below could indicate a COVID-19 infection in children and may put your child at risk for spreading illness to others. Please note that this list does not include all possible symptoms and children with COVID-19 may experience any, all, or none of these symptoms. Please check your child daily for these symptoms:

Column A	Column B
❑ Feverish (subjective) ☐ Chills ☐ Rigors (shivers) ☐ Myalgia (muscle aches) ☐ Headache ☐ Sore Throat ☐ Nausea/Vomiting** ☐ Diarrhea** ☐ Fatigue ☐ Congestion or runny nose ***Please note that anyone with vomiting or diarrhea should stay home until 24 hours free of vomiting/diarrhea.*	❑ Fever (above 98.6 on a thermometer) ☐ Cough ☐ Shortness of Breath ☐ Difficulty Breathing ☐ New loss of smell ☐ New loss of taste ***Please note that anyone with vomiting or diarrhea should stay home until 24 hours free of vomiting/diarrhea.* PLEASE take your child's temperature!

If **TWO OR MORE of the fields in Column A** are checked off **OR AT LEAST ONE field in column B is checked off**, please keep your child home and notify the school for further instructions.

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