



Weekly Student Health Screening

Date _____

Child's Name _____

Homeroom _____

Has your child come in close, regular contact (within 6 feet) of someone who has a laboratory confirmed COVID-19 diagnosis within the past 14 days?

Yes No

Does your child have any of the following: fever or chills, cough, shortness of breath or difficulty breathing, body aches, headache, new loss of taste or smell, sore throat?

Yes No

Has your child traveled to any of the states on currently on the Advisory List in the last 14 days?

Yes No

Does your child feel well today?

Yes No