Weekly **STUDENT** Health Screening

Date _____

Name _____

Grade/Class _____

Has your child come in close, regular contact (within 6 feet) of someone who has a laboratory confirmed COVID-19 diagnosis within the past 10 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 out of the country in the last 14 days?

Yes ☐ No ☐