Self-screening tool for COVID – 19 for staff, faculty, and families

Date completed:

Month/day/year

Are you showing any signs of the following symptoms?

- Feeling feverish or temperature of 100.0 Fahrenheit? , if yes what time?

  Fever-reducing medication taken? Time:

The following are yes or no questions

- Chills or repeated shaking with chills?
- Shortness of breath or difficulty breathing? If yes, explain:
- Cough?
- Headache?
- Sore throat?
- Muscle pain?
- New loss of taste or smell?
- Any nausea/vomiting/diarrhea?
- Have you traveled out of the Continental us in the last 14 days? If yes, Where?
- Have you been exposed to someone diagnosed to COVID – 19 in the last 14 days?

If you answered yes to any of these questions please do not report to school/work today, contact:

ICCS Office / (940)381-1155

Name Phone number/email

- If you answered no to all these questions, please return to school/work today

Stay well together, thank you!