



## Visitation Academy – COVID 19 Screening Tool

Date \_\_\_\_\_

Parents/Guardians: Please complete this short check list each morning and hand it to the school personnel at the entrance

Temperature taken within one hour of school drop-off without fever reducers: \_\_\_\_\_

When your child woke up this morning did he/she have any of the following?

A \_\_\_\_\_

B \_\_\_\_\_

Chills/Shivers

Cough

Congestion/ runny nose

Difficulty breathing

Diarrhea

Loss of Smell

Fatigue

Loss of Taste

Fever

Shortness of Breath

Headache

Muscle Aches

Nausea/Vomiting

Sore Throat

**If two or more fields in *Column A* are checked or one in *Column B* are checked, please keep your child home and notify the school office.**

As of this morning, has your child been within 6 feet of a COVID-19 infected person? \_\_\_\_\_

Has someone in your household been diagnosed with COVID-19? \_\_\_\_\_

Has your child traveled to an area of high community transmission? \_\_\_\_\_

**If ANY of the above answers YES**, your child should stay home and not come to school. They should quarantine for 14 days and receive clearance from a doctor to return to school.

Child's Name \_\_\_\_\_

Grade \_\_\_\_\_