Visitation Academy – COVID 19 Screening Tool

Student Form

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?

_ Chills/Shivers

_ Congestion/ runny nose

_ Diarrhea

_ Fatigue

_ Fever

_ Headache

_ Muscle Aches

_ Cough

_ Difficulty breathing

_ Loss of Smell

_ Loss of Taste

_ Shortness of Breath

_ Nausea/Vomiting

_ Sore Throat

If your child is experiencing any <u>one</u> of the above symptoms, 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 within the past 14 days?
- Has your child recently traveled out of state within the past 14 days?
- Has your child recently attended a large gathering within the past 14 days?

If you have answered <u>YES</u> to any of the above, please contact school office as your child may need to quarantine for an additional period time according to CDC Guidelines.

<u>Please remember if anyone in your household has tested positive please contact the school office</u>.

Child's Name: _____ Grade: _____