

My Child: _____

Room: _____ Date: _____

Does he/she have/show:	Yes	No
1. a temperature below 99.0		
2. Any of the following symptoms - Cough, sore throat, congestion or runny nose, shortness of breath, muscle/body aches, nausea/vomiting or diarrhea		
3. Loss of smell/taste		
4. Anyone in the family with symptoms or exposure to someone testing positive for COVID?		

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