Name_______________ Grade__________
Date______________

In the past 10 days was the student...

▢ sent home or absent due to illness?

▢ diagnosed with COVID 19 or have a test confirming they had the virus?

In the past 14 days has the student...

▢ had close contact with anyone **in the household** who was diagnosed with COVID 19 or had a test confirming they had the virus?

▢ had close contact with someone **outside the household** who was diagnosed with COVID 19 or had a test confirming they had the virus?

Please check Yes or No below. If any answers are YES, please do not send your child to school.

	YES	NO
Fever (100.4 or above)?	▢	▢
Cough or sore throat?	▢	▢
Headache?	▢	▢
Chills or body aches?	▢	▢
Nausea, vomiting, diarrhea?	▢	▢
Loss of taste or smell?	▢	▢
Difficulty breathing?	▢	▢
Congestion or runny nose?	▢	▢

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