Daily Health Screening Card

Student Name: ____________________

SYMPTOMS?

Date: __________

Is your student exhibiting any of the following that cannot be attributed to another pre-existing health condition:

- Temperature of 100.4 or higher or chills
- Cough, new/uncontrolled or that causes difficulty breathing
- Shortness of breath
- Unusual fatigue
- Muscle or body aches
- Headache, new onset
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea, vomiting or diarrhea

____
Temperature reading taken at home

Temp @ school: ________

☐ **No to all** (proceed to next question)

☐ **Yes to any** (keep student home; call school to report absence)

CLOSE CONTACT/POTENTIAL EXPOSURE?

Has your student had any of the following:

- Close contact with a person with confirmed COVID-19
- Positive COVID-19 test in the past 10 days
  - Concerns about possible COVID-19 infection voiced by a public health/medical professional in past 14 days?

☐ **No to all** (proceed)

☐ **Yes to any** (keep student home; call school to report absence)

Parent initial: __________________

If NO to all, send your student to school with:

1.) This completed card **2.) Face covering**

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