Student Name: _____ Date:_____

DAILY COVID HEALTH SCREENING

Fever, cough, chills, and/or muscle aches	YES	NO
Sore throat, runny nose and/or loss of taste or smell	YES	NO
Nausea, vomiting, and/or diarrhea	YES	NO
Shortness of breath and/or headache	YES	NO
Close contact or cared for someone with COVID-19	YES	NO
Temperature higher than 100.4 F	YES	NO

Parent Signature:_____

Student Name: _____ Date:_____

DAILY COVID HEALTH SCREENING

Fever, cough, chills, and/or muscle aches	YES	NO
Sore throat, runny nose and/or loss of taste or smell	YES	NO
Nausea, vomiting, and/or diarrhea	YES	NO
Shortness of breath and/or headache	YES	NO
Close contact or cared for someone with COVID-19	YES	NO
Temperature higher than 100.4 F	YES	NO

Parent Signature:_____

Student Name: _____ Date:_____

DAILY COVID HEALTH SCREENING

Fever, cough, chills, and/or muscle aches	YES	NO
Sore throat, runny nose and/or loss of taste or smell	YES	NO
Nausea, vomiting, and/or diarrhea	YES	NO
Shortness of breath and/or headache	YES	NO
Close contact or cared for someone with COVID-19	YES	NO
Temperature higher than 100.4 F	YES	NO

Parent Signature:_____

Student Name: _____ Date:_____

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Parent Signature:_____