

# Covid-19 Health Assessment

## Self Assessment Form

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Please complete this form before school EVERY DAY your child attends in person. If you answer "yes" to any of these questions you MAY NOT enter the building. Consult the Covid-19 Protocol posted on the sign-in page or contact the school.

**\*\*Please note that question #6 was CHANGED on 3/25/21.\*\***

Have you had a fever of >100 degrees Fahrenheit or felt feverish in the last 72 hours?	<input type="radio"/> Yes <input type="radio"/> No
Are you experiencing any new respiratory symptoms including a runny nose, sore throat, congestion, cough, or shortness of breath?	<input type="radio"/> Yes <input type="radio"/> No
Are you experiencing any new muscle aches, headaches, chills or severe fatigue?	<input type="radio"/> Yes <input type="radio"/> No
Have you experienced any new change in your sense of taste or smell?	<input type="radio"/> Yes <input type="radio"/> No
Are you experiencing any new onset GI symptoms? These include new nausea, vomiting, and diarrhea.	<input type="radio"/> Yes <input type="radio"/> No
<b>**UPDATED**</b> : Have you traveled internationally or by cruise ship in the prior 10 days?	<input type="radio"/> Yes <input type="radio"/> No
Have you been exposed to a person who has tested positive to COVID-19 in the past 10 days?	<input type="radio"/> Yes <input type="radio"/> No
Have you been exposed to anyone EXPERIENCING COVID-19 LIKE SYMPTOMS over the last 10 days, who has NOT YET BEEN TESTED, or IS AWAITING RESULTS?	<input type="radio"/> Yes <input type="radio"/> No

**Thank you. If you answered "yes" to any of these questions you MAY NOT enter the building. Please review the COVID-19 health protocol on the sign-in page, or notify your school for further instruction.**

Done