COVID-19 SCREENING FORM

STUDENT NAME: _____ _____

Signature of Parent

ANY STUDENT ANSWERING YES TO ANY QUESTION OR RECORDING A TEMPERATURE OF 100 OR ABOVE MUST STAY AT HOME.

DATE	FEVER		SORE THROAT		COUGH		LOSS OF SMELL OR TASTE		SHORTNESS OF BREATH		CLOSE CONTACT TO POSITIVE COVID PATIENT		TEMP	Parents Initials
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		