COVID-19 SYMPTOM ASSESSMENT

Student Name:Date and time: **Sent Home: Y/N Parent/Guardian Notified: Y / N**

COVID-19 Symptoms	Presence of Symptoms	Date of onset	Duration
Fever	Y / N / U / R		Number of days
Cough	Y / N / U / R		
Diarrhea/GI	Y / N / U / R		
Headache	Y / N / U / R		
Muscle ache	Y / N / U / R		
Chills	Y / N / U / R		
Sore Throat	Y / N / U / R		
Vomiting	Y / N / U / R		
Abdominal pain	Y / N / U / R		
Nasal congestion	Y / N / U / R		
Loss of sense of smell	Y / N / U / R		
Loss of sense of taste	Y / N / U / R		
Malaise	Y / N / U / R		
Fatigue	Y / N / U / R		
Shortness of Breath or difficulty/trouble breathing*	Y / N / U / R		
Persistent pain or pressure in the chest*	Y / N / U / R		
New confusion*	Y / N / U / R		
Inability to wake or stay awake*	Y / N / U / R		
Bluish lips or face*	Y / N / U / R		
Other symptom(s)	Y / N / U / R		

- Emergency warning signs- Persons with these symptoms should be referred for emergency medical care.

Key: Y=yes, N= no, U=unknown, R=refused

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