Winlock School District

401 NE 1st Street PO Box 128 Winlock, WA 98596 --- Phone: 360-785-3582 — Fax: 360-262-6651
Superintendent: Garry Cameron, Office Professional: Erika Lopez, Business Manager: Myrna Gillihan: Payroll: Gloria Dupree

COVID-19 SCREENING FORM

Please complete this form to assess your potential exposure to or diagnosis of COVID-19 or other illnesses.

Student Name: _____ Grade:_____

Parent/Guardian Name:_____

Address:_____

City:_____. State: _____. Zip Code:_____

Parent/Guardian Phone Number:_____

School: _____

DOB:_____ Age: _____

QUESTION	YES	NO
Do you have a family or household member diagnosed with the COVID-19 virus currently or in the past?		
Have you had any of the following symptoms in the past two weeks?		
• Fever (100.4 or greater)		
• Cough		
• Shortness of breath or difficulty breathing		
• Shaking chills		
• Chest pain, pressure, or tightness		
• Fatigue or difficulty with exercise		
• Loss of taste or smell		
• Persistent muscle aches or pains		
• Sore Throat		
• Nausea, vomiting, or diarrhea		
• New uncontrolled cough that causes difficulty breathing (for individuals with chronic allergic/asthmatic cough, a changed in their cough from baseline)		
Do you have moderate to severe asthma, a heart condition, diabetes, or a weakened immune system?		

Have you been diagnosed or tested positive for COVID-19 infection?

( ) YES ( ) NO DATE OF TEST: _____/_____/_____

If you had COVID-19 infection,

- During the infection, did you suffer from chest pain, pressure, tightness or heaviness, or experience difficulty breathing or unusual shortness of breath?

  ( ) YES ( ) NO
- Since the infection, have you had new chest pain or pressure with exercise, new shortness of breath with exercise, or decreased exercise tolerance?

  ( ) YES ( ) NO

* **Should any of your information/answers change, please notify the school's administration IMMEDIATELY.**

Student Signature: _____ Date: _____

Parent Signature: _____ Date: