

COVID-19 Student Self-Screening Form

Screen your child before leaving for school or sending them to school. If your child shows symptoms of COVID-19, do not send them to school.

Section 1: In the last 24 hours, has your child developed any of the following symptoms that are new/different/worse from baseline of any chronic illness:

Cough:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Shortness of breath:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Difficulty breathing:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
New loss of smell:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
New loss of taste:	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Section 2: In the last 24 hours, has your child developed any of the following symptoms that are new/different/worse from baseline of any chronic illness:

Subjective fever (felt feverish) or measured temperature of 100.4°F or higher:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chills or rigors (severe chills with shivering):	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Headache:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sore throat:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Runny nose or congestion:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Muscle aches:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fatigue:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Nausea:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Vomiting:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diarrhea:	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If you answer **YES** to any of the symptoms listed in **Section 1**, **OR YES** to two or more of the symptoms listed in **Section 2**, please do not send your child to school. Self-isolate at home and contact your healthcare provider for direction and possible testing for COVID-19.

In the past 14 days, has your child:

Had close contact with an individual who has tested positive for COVID-19?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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If you answer **YES** to the above question, please do not send your child to school. Self-quarantine at home for 10 days. Contact your healthcare provider if your child has symptoms.

