Daily Home Screening for Students

Parents: Please complete this short check each morning and report your child's information. Please return this copy with your registration.

SECTION 1: Symptoms

If your child has any of the following symptoms, that indicates a possible illness that may decrease the student's ability to learn and also put them at risk for spreading illness to others. Please check your child for these symptoms:

☐	Temperature 99.0 degrees Fahrenheit or higher when taken by mouth
☐	Sore throat
☐	New uncontrolled cough that causes difficultly breathing (for students with chronic allergic/asthmatic cough, a change in their cough from baseline)
☐	Diarrhea, vomiting, or abdominal pain
☐	New onset of severe headache, especially with a fever

SECTION 2: Close Contact/Potential Exposure

☐	Had close contact (within 6 feet of an infected person for at least 15 minutes) with a person with confirmed or suspected COVID-19
☐	Traveled or live with someone who has traveled out-of-state within the last 14 days
☐	Live in areas of high community transmission while the schools remain open

I have read the above and agree to keep my child at home if any of the answers above is "yes".

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Signature *Date*