Covid Screening

Date: ________________ Student/Staff Name: ______________________________________

Temperature: ____________ Screened by: ______________________________________

If greater than 100.4 F, notify Principal

Any COVID Symptoms? [ ] YES [ ] NO If yes indicate which ones from the list below:

[ ] cough [ ] shortness of breath [ ] muscle pain [ ] headache [ ] sore throat [ ] new loss of taste/smell

[ ] diarrhea [ ] nausea/vomiting [ ] chills/repeated shaking with chills

COVID Contact: Have you had any contact with someone that is suspected or confirmed as having COVID? [ ] Yes [ ] No

Staff Signature: ____________________________________

Parent Signature_______________________________________

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