Daily Health Screening- Student

This Daily Heath Screening is required to be completed each day before entrance to school.

1. Is your child , or a household member currently waiting for the results of a COVID-19 test?

   No _____ **GO**. You may go to school.

   Yes _____ **STOP**. You may not go to school.

2. In the past 10 days, Has your child experienced any symptoms of COVID-19 , including a fever of 100.0 F or greater, new cough, loss of taste or smell, shortness of breath, sore throat, headache, nasal congestion, runny nose (sniffles), stomach upset?

   No _____ **GO**. You may go to school.

   Yes _____ **STOP**. You may not go to school.

3. In the past 10 days has your child gotten a lab confirmed positive COVID-19 test result (not a blood test) that was their first positive COVID-19 result OR was 90 days from their previous positive COVID-19 result? Please note the 10 days is measured from the day you were tested, not the day you received the results.

   No _____ **GO**. You may go to school.

   Yes _____ **STOP**. You may not go to school.

4. To the best of your knowledge , in the past 10 days has your child been in close contact (within 6 feet for at least 10 minutes over 24 hour period) with anyone who has tested positive for COVID -19 or who has been told they have symptoms of COVID-19 ?

   No _____ **GO**. You may go to school.

   Yes _____ **STOP**. You may not go to school.

5. In the past 10 days has your child or a household member returned from an international destination?

   No _____ **GO**. You may go to school.

   Yes _____ **STOP.** You may not go to school.

Student Name:_____ Grade:_____

Parent Signature: _____

Date:_____

Revised April 8, 2021