Name ________________ Date ___________

Does the student have a temperature 100.4 or higher without the aid of fever reducing medications? ☐ No ☐ Yes ☐ Please check

Does the student have any of the following symptoms:

☐ Cough or shortness of breath
☐ Chills
☐ Fatigue
☐ Muscle/body aches
☐ Sudden, severe headache
☐ Sore throat
☐ New loss of taste or smell
☐ Congestion/runny nose
☐ Nausea, vomiting, diarrhea
☐ None of the above

Has the student been in close contact with someone positive for COVID-19?

☐ No ☐ Yes

Has the student travelled to a high-risk area where the local health department is reporting a large number of cases? ☐ No ☐ Yes

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