COVID-19 Daily Screening Form

Part A:

In the past 24 hours, have you experienced any Flu Like symptoms? If you answered YES to any of the symptoms listed below STOP! You will not be admitted to the facilities. You must self-isolate at home and contact your primary care doctor for directions.

- ☐ Sore Throat
- ☐ Cough
- ☐ Fever
- ☐ Other Fly symptoms, headache, nausea, or runny nose
- ☐ NONE of the ABOVE
- ☐ Other:

Part B:

In the Past 14 days, have you: Had close contact, i.e. within 6 feet, of a person diagnosed with COVID-19? Or traveled internationally by plane? If you answered YES you are not permitted to enter the facilities and should self-quarantine at home for 14 days following close contact with the COVID-19 positive person or return from international travel. **Please NOTIFY the School Office if you answered YES to any of the A or B questions.

- ☐ YES
- ☐ NO
- ☐ Other

****Must do daily health screening prior to coming to school****