PORT ANGELES SCHOOL DISTRICT

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COVID-19 SCREENING FORM –STUDENTS

Please complete this form to assess your student's potential exposure to or diagnosis of COVID-19 or other illnesses.

Student's Name: _____ School: _____ Grade: _____ Date: _____

Question	YES	NO
Has your student, or anyone in your household, been in close contact with anyone with confirmed COVID-19 in the last 14 days?		
Has your student, or anyone in your household, had a positive COVID-19 test for active virus in the past 10 days, or are awaiting results of a COVID-19 test?		
Within 14 days, has a public health or medical professional told your student, or anyone in your household, to self-monitor, self-isolate, or self-quarantine because of concerns about COVID-19?		
Has your student traveled outside of Washington State in the past 14 days?		
Has your student, or anyone in your household, had any of the following symptoms that are not caused by another condition in the past 72 hours?		
• Fever (100.4) or chills		
• Cough		
• Shortness of breath or difficulty breathing		
• Unusual Fatigue		
• Muscle or body aches		
• Headache		
• Recent loss of taste or smell		
• Sore Throat		
• Congestion or runny nose		
• Nausea, vomiting, or diarrhea		

If you answered yes to any of the above questions, then we kindly ask that your student not attend school today.

Guardian/Student Signature: _____

Printed Name: _____

Phone Number: _____

January 27, 2021