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*Board of Directors* • Cindy Kelly • Sandy Long • Katie Marks • Sarah Methner • Jacob Wright

# 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 been in close contact with anyone with confirmed COVID-19? | | |
| Has your student had a positive COVID-19 test for active virus in the past 10 days? | | |
| Within 14 days, has a public health or medical professional told your student to self-monitor, self-isolate, or self-quarantine because of concerns about COVID-19? | | |
| Has your student 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 Signature: ____________________________________________________

Printed Name: ________________________________________________________

Phone Number: _______________________________________________________