

**COVID 19 SCREENING QUESTIONS**

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Student\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/Caretaker\_\_\_\_\_\_\_\_\_\_**

**Staff\_\_\_\_\_\_\_\_\_\_\_\_**

**Visitor\_\_\_\_\_\_\_\_\_\_**

Do you have any of the following symptoms:

* Fever of over 100.4
* Cough (newly developed)
* Shortness of breath or difficulty breathing
* Fatigue and/or muscle or body aches
* Headache
* New loss of taste or smell
* Sore throat
* Congestion or runny nose
* Diarrhea

Been in close contact in the last 10 days with anyone who has tested positive for Covid 19 or who has had symptoms of Covid 19

Tested positive through a diagnostic test for Covid 19 in the past 10 days

Traveled internationally in the past 10 days.

 No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If you answered Yes to any of the above, you may not enter the building**

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (4-01-21 update)