

**Symptom Screening Checklist  
Adult Reporting for Student**

Name \_\_\_\_\_ Grade \_\_\_\_\_

**ANYONE SHOWING SYMPTOMS OF COVID-19 OR WHO MAY HAVE BEEN EXPOSED SHOULD NOT BE AT SCHOOL.**

Since this child was last at school, has s/he been diagnosed with COVID-19?

- YES
- NO

Has this child had close contact (within 6 feet for at least 10 minutes) with someone diagnosed with COVID-19 in the last 14 days, or has any health department or health care provider been in contact with you and advised you to quarantine?

- YES
- NO

Does this child have any of the symptoms below?

- Fever (100.1 or higher)
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore Throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

**If a child has any of these symptoms, s/he should go home, stay away from other people, and the family should contact the child's healthcare provider.**

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