Health Screening Form

Please have this ready when arriving at Preschool, Children, or Student Areas.

either question or have a temperature >100°F.

Date:	Date:
mm/dd/yyyy	mm/dd/yyyy
Participant's name (First Last)	Participant's name (First Last)
Has the participant exhibited any COVID-19 related symptoms in the last 48 hrs? YES NO	Has the participant exhibited any COVID-19 related symptoms in the last 48 hrs? YES NO
including temperature >100°F, sore throat, new cough, new breathing difficulty, severe headache, diarrhea, vomiting, loss of taste or smell, undiagnosed rash, or muscle pains	including temperature >100°F, sore throat, new cough, new breathing difficulty, severe headache, diarrhea, vomiting, loss of taste or smell, undiagnosed rash, or muscle pains
Has the participant been in close contact with anyone confirmed COVID-19 positive in the last 14 days? YES NO	Has the participant been in close contact with anyone confirmed COVID-19 positive in the last 14 days? YES NO
What was the temperature of the participant as measured at home this morning?°F	What was the temperature of the participant as measured at home this morning?°F
We ask that you stay home if you answered "YES" to either question or have a temperature >100°F.	We ask that you stay home if you answered "YES" to either question or have a temperature >100°F.
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