Health Screening Form

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

Date:_____
mm/dd/yyyy

_____
Participant's name (First Last)

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*

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

We ask that you stay home if you answered "YES" to either question or have a temperature >100°F.

Health Screening Form

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

Date:_____
mm/dd/yyyy

_____
Participant's name (First Last)

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*

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

We ask that you stay home if you answered "YES" to either question or have a temperature >100°F.

Health Screening Form

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

Date:_____
mm/dd/yyyy

_____
Participant's name (First Last)

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*

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

We ask that you stay home if you answered "YES" to either question or have a temperature >100°F.

Health Screening Form

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

Date:_____
mm/dd/yyyy

_____
Participant's name (First Last)

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*

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

We ask that you stay home if you answered "YES" to either question or have a temperature >100°F.