St. Theresa School COVID-19 Daily Student Health Screening

Student Name_____
Grade_____ **Date** _____

Please check **YES** or **NO** if any of the following pertain to your child's health within the last 3-5 days. One form for each child, please.

Does your child have:	**YES**	**NO**
Fever 100.4 degrees or greater?	▢	▢
Chills, congestion, runny nose, or sore throat?	▢	▢
Cough; shortness of breath or difficulty breathing; or loss of taste or smell?	▢	▢
Fatigue, muscle/body aches, headache, diarrhea, nausea or vomiting?	▢	▢
Has your child been in close contact with anyone diagnosed with COVID-19 or anyone who has been placed in quarantine for possible exposure of COVID-19?	▢	▢
Has anyone in your household been asked to self-isolate or quarantine by a medical professional or local public health official?	▢	▢

If you have answered **YES** to **any** of the above screening questions, please DO NOT send your child to school. Please contact the school and your healthcare provider for further direction and guidance.

If you answered **NO** to all the questions, send your child to school with their face covering, this completed screening sheet and reminders to socially distance and wash their hands.

Parent Initials: _____

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Grade_____ **Date** _____

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