COVID-19 Daily Screening for Students

Student Name_____ **Date**_____

Signature _____

☐ Currently, my child is experiencing **"NO"** Covid-19 related symptoms

Section 1: *Any of the symptoms below could indicate a COVID-19 infection in children and may put your child at risk for spreading illness to others. Please note that this list does not include all possible symptoms and children with COVID-19 may experience any, all, or none of these symptoms. Please check your child daily for these symptoms.*

Please check if your student is experiencing any of these symptoms:

☐Chills ☐Rigors (shivers) ☐Myalgia (muscle aches) ☐Nausea ☐Headache ☐Sore throat

☐Diarrhea ☐Fatigue ☐Congestion or runny nose ☐Fever (measured or subjective) ☐Vomiting

☐Cough ☐Shortness of breath ☐Difficulty breathing ☐New loss of smell ☐New loss of taste

Section 2: Close Contact/Potential Exposure: Please verify if:

☐ Your child has had direct contact with a person who tested positive for COVID-19.

☐ Someone in your household is diagnosed with COVID-19 or waiting on test results (stay home from school).

☐ Your child has traveled to an area outside NJ, NY,CT, PA or DE.

*If **ANY of the fields in Section 1 or 2** are checked off- **Your child should remain home from school** and please notify the school nurse and contact your child's health care provider for further guidance. Thank you.*