CHILD'S NAME: _____

1. Has your child or anyone in your household had any COVID-19 symptoms in the last 24 to 72 hours? Symptoms might include: coughing, sneezing, shortness of breath, sudden loss of smell, chills, body aches/pains, fever, sore throat, runny nose.
   ____YES ____ NO
2. Has your child or anyone in your household been in contact with anyone who has tested positive for COVID-19 or is in the process of being tested?
   ____ YES ____ NO
3. Is your child or anyone in your household currently awaiting results from a COVID-19 Test?
   ____ YES ____ NO
4. Has your child taken any fever reducing medicine in the last 24 hours?
   ____ YES ____ NO

Parent, please initial confirming all of the above: _____

DATE:_____

Temperature reading at school: _____

CHILD'S NAME: _____

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DATE:_____

Temperature reading at school: _____