Questions and Answers during COVID-19:

1. Has your child tested positive for COVID-19 in the past 14 days?	YES	NO
2. Has your child had close contact (within 6 feet) with a person with COVID-19 for a prolonged period of time (10 minutes or more) in the past 14 days?	YES	NO
3. Does your child have a cough?	YES	NO
4. Does your child have shortness of breath or difficulty breathing?	YES	NO
5. Does your child have a fever (temperature of 100.4°F or higher) without taking any fever-reducing medications?	YES	NO
6. Is your child experiencing fatigue?	YES	NO
7. Does your child have chills?	YES	NO
8. Does your child have muscle or body aches?	YES	NO
9. Does your child have a headache?	YES	NO
10. Does your child have a sore throat?	YES	NO
11. Does your child have a loss of taste or smell?	YES	NO
12. Does your child have congestion or a runny nose?	YES	NO
13. Did your child experience any new gastrointestinal symptoms such as nausea/vomiting, diarrhea, loss of appetite within the last 24 hours?	YES	NO

Please note if the answer is YES to any of the questions your child will need to remain home. Please complete form and bring it with you.

Child's name _____

Parent's signature and date _____