STUDENT/STAFF COVID-19 HEALTH SCREENING FORM

Name:_____ **Grade:** _____

Date:_____ **Time:**_____ **Temperature**:_____

Questions	Circle Yes/No	
Do you have a fever?	Yes	No
Do you have a cough?	Yes	No
Do you have a sore throat?	Yes	No
Do you have congestion or a runny nose?	Yes	No
Do you have trouble breathing or shortness of breath?	Yes	No
Do you have a new loss of taste or smell?	Yes	No
Do you have any nausea, vomiting, or diarrhea? Which?	Yes	No
Do you have any headache or body aches?	Yes	No
Have you had close contact with anyone diagnosed with COVID-19 within last 14 days?	Yes	No

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