(Child's Name) **COVID-19 Daily Health Screening**

Today or in the past 24 hours, have you or any household members had any of the following symptoms?

- Fever (temperature of 100. 0°F or above), felt feverish, or had chills?
- Cough?
- Sore throat?
- Difficulty breathing?
- Gastrointestinal symptoms (diarrhea, nausea, vomiting)?
- Headache?
- New loss of smell/taste?
- New muscle aches?
- Any other signs of illness?
- In the past 14 days, have you had close contact with a person known to be infected with the novel coronavirus (COVID-19)?

By signing below you are attesting that the answer to all of the above questions is "NO":

Date	Temp	Parent/Caregiver Signature