PURPOSE SCHOOL DAILY HEALTH SCREENING

DATE: _____

CHILD/STAFF MEMBER: _____

Today or in the past 24 hours, have you (PS staff), your child (PS children) or any household members had any of the following symptoms?

• Fever (temperature of 100.0°F or above), felt feverish, or had chills?

(Must be fever free 48 hours before returning to school)

• Cough?

• Sore throat?

• Difficulty breathing?

• Gastrointestinal symptoms (diarrhea, nausea, vomiting)?

• Fatigue? (with other symptoms)

• Headache? (with other symptoms)

• 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 coronavirus (COVID-19)? *If anyone in your household has been tested for Covid, the whole family cannot attend school until a negative test is returned. When you return you must hand in a copy of the negative report which will be placed in your child's file.*

I attest that my child has not exhibited any of the above symptoms and has not taken any medication to mask the above symptoms (ex. Tylenol).

Signature of staff member or parent: _____

Phone number to reach me today: _____

Picking up my child today is: _____

Any notes to the teacher today: _____

_____

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