COVID-19 Daily Wellness Pre-Screening Questionnaire
This must be completed each school day for each student

Student Name: _____ **Today's Date:** _____

PART 1

Has the student been diagnosed with COVID-19, or been placed on quarantine for possible contact with COVID-19?	☐ Yes ☐ No
Has the student been asked to self-isolate or quarantine by a medical professional or local public health official?	☐ Yes ☐ No
Does the student have a fever (temperature of 100^{O}F or higher) without having taken any fever reducing medications (Tylenol, acetaminophen, Advil, Motrin, ibuprofen, etc.)?	☐ Yes ☐ No
○ What is the student's temperature?	_____
Does the student have a new loss of smell or taste?	☐ Yes ☐ No
Does the student have shortness of breath?	☐ Yes ☐ No
Does the student have a persistent cough not due to allergies?	☐ Yes ☐ No

STOP! If ANY ONE or more of the answers in Part 1 is YES, the student must stay home!

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PART 2

Does the student have muscle aches not due to exercise?	☐ Yes ☐ No
Does the student have a sore throat?	☐ Yes ☐ No
Does the student have chills, not due to environmental temperature?	☐ Yes ☐ No
Does the student have a new, severe headache?	☐ Yes ☐ No

STOP! If TWO or more of the answers in Part 2 is YES, the student must stay home!

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If the student may come to school (no YES answers in Part 1, no more than 1 YES answer in Part 2), please bring this form to school with the student