

COVID-19 Student Self-Screening Form

Screen your child before leaving for school or sending them to school. If your child shows symptoms of COVID-19, do not send them to school.

Section 1: In the last 24 hours, has your child developed any of the following symptoms that are new/different/worse from baseline of any chronic illness:

| | | |
|-----------------------|------------------------------|-----------------------------|
| Cough: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Shortness of breath: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Difficulty breathing: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| New loss of smell: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| New loss of taste: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Section 2: In the last 24 hours, has your child developed any of the following symptoms that are new/different/worse from baseline of any chronic illness:

| | | |
|--|------------------------------|-----------------------------|
| Subjective fever (felt feverish) or measured temperature of 100.4°F or higher: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chills or rigors (severe chills with shivering): | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Headache: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sore throat: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Runny nose or congestion: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Muscle aches: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Fatigue: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Nausea: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Vomiting: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diarrhea: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If you answer **YES** to any of the symptoms listed in **Section 1**, **OR YES** to two or more of the symptoms listed in **Section 2**, please do not send your child to school. Self-isolate at home and contact your healthcare provider for direction and possible testing for COVID-19.

In the past 14 days, has your child:

| | | |
|--|------------------------------|-----------------------------|
| Had close contact with an individual who has tested positive for COVID-19? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|--|------------------------------|-----------------------------|

If you answer **YES** to the above question, please do not send your child to school. Self-quarantine at home for 10 days. The quarantine period may be reduced to 7 days if the contact receives a negative viral (PCR or antigen) test performed at least 5 days after exposure. Quarantine is not necessary for students diagnosed with COVID-19 in the past 3 months, for students who are fully vaccinated against COVID-19, or for students exposed only in the classroom, while both the index case and close contact were masked and sitting at least 3 feet apart, or for students exposed only in the classroom, while both the index case and the close contact were masked and sitting less than 3 feet apart if the contact tests daily for 7 days. Contact your healthcare provider if your child has symptoms.

