STUDENT DAILY HEALTH SCREENER - *FAST PASS*

Parents complete this form daily

Date: ____________

Student Name: ________________________

Parent Signature: ________________________

Y	**N**	In the last 14 days, has anyone in your household had close contact with someone who has or is suspected to have COVID-19?

Y	**N**	Has anyone in your household been tested for COVID-19 and is waiting for test results?

In the last 12 hours, has your child experienced any of the following symptoms?

Y	**N**	FEVER (over 100.4)	**Y**	**N**	CHILLS
Y	**N**	HEADACHE	**Y**	**N**	MUSCLE ACHES
Y	**N**	COUGH	**Y**	**N**	SORE THROAT
Y	**N**	SHORTNESS OF BREATH	**Y**	**N**	GASTROINTESTINAL (nausea, vomiting, diarrhea)
Y	**N**	LOSS OF TASTE AND SMELL			

rev. 12/1/2020

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