
RAZI SCHOOL

COVID-19 SCREENING QUESTIONNAIRE

NAME:

DATE:

GRADE:

TIME OF ARRIVAL:

Does your child have:

A fever (temperature over 100.4° F) without having taken any fever-reducing medications? YES [] NO []

A loss of smell or taste? YES [] NO []

A cough? YES [] NO []

A sore throat? YES [] NO []

A runny nose? YES [] NO []

Shortness of breath? YES [] NO []

Chills? YES [] NO []

Have you, or anyone you have been in close contact with, been diagnosed with COVID-19 or placed in quarantine for possible exposure to COVID-19 within the last two weeks?

YES []

NO []

IF THE ANSWER TO ANY OF THE QUESTIONS ABOVE IS “YES”, STAY HOME AND SEEK MEDICAL ATTENTION