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 [ ]
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, traveled out of State 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