COVID-19 SYMPTOM SCREENING TOOL

*Use this daily before school/work. Please contact the School Nurse at any time with questions you may have about the screening tool or illness symptoms. You **do not** need to turn this form into the school.

Please take your temperature. If it is 100°F or higher, please stay home and contact your primary care provider.

Question 1:
In the past 14 days, has the student / have you been exposed to anyone diagnosed with COVID-19?

Question 2:
In the past 24 hours, has the student / have you taken any medication to treat or reduce a fever, such as ibuprofen (i.e. Advil, Motrin) or acetaminophen (Tylenol)?

Question 3:
In the past 3 days, has the student / have you experienced:

any **ONE** (or more) of the following symptoms in Group A,

OR

any **TWO** (or more) of the following symptoms in Group B (below)?

Group A 1 or more symptoms	Group B 2 or more symptoms
Fever (100°F or higher) Cough Shortness of breath Difficulty breathing	Sore throat Runny nose/congestion Chills New lack of smell or taste Muscle pain Nausea or Vomiting Headache Diarrhea

*****If you or the student answered yes to any of the above 3 questions, keep student at home / stay home and contact your primary care provider. Please notify the school nurse of any positive COVID-19 test or exposure.**

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