

COVID-19 Daily Self Checklist

Students

Instructions:

- Parents and guardians of all students are required to screen their student according to this checklist each day and take the student's temperature before sending a student to school. By sending a student to school, you certify that you and your student have honestly answered NO to all of the Questions below.
- If the student answers NO to all Questions, the student may attend school that day.
- If the student answers YES to any of the Questions below, the student must not be sent to school.
- After exhibiting symptoms, students are required to meet all return-to-school criteria before returning to school.
- If a student starts feeling sick during school or experiences the symptoms listed below, the student will be sent home immediately.

| Questions | Yes | No |
|---|--------------------------|--------------------------|
| Does the student have a temperature of 100.4°F or greater? | <input type="checkbox"/> | <input type="checkbox"/> |
| Is the student taking fever-reducing medicines, such as those that contain aspirin, ibuprofen or acetaminophen, in order to reduce the student's fever? | <input type="checkbox"/> | <input type="checkbox"/> |
| Has the student had close contact or cared for someone with COVID-19 within the past 14 days? | <input type="checkbox"/> | <input type="checkbox"/> |
| Has the student returned from travel outside the United States or on cruise ship or river boat within the past 14 days? | <input type="checkbox"/> | <input type="checkbox"/> |
| Has the student been directed to self-quarantine by a health care provider? | <input type="checkbox"/> | <input type="checkbox"/> |
| Has the student been directed to self-quarantine by the County or State Department of Public Health? | <input type="checkbox"/> | <input type="checkbox"/> |
| Is the student experiencing any of the following symptoms? | | |
| • Chills | <input type="checkbox"/> | <input type="checkbox"/> |
| • Cough | <input type="checkbox"/> | <input type="checkbox"/> |
| • Shortness of breath or difficulty breathing | <input type="checkbox"/> | <input type="checkbox"/> |
| • Fatigue | <input type="checkbox"/> | <input type="checkbox"/> |
| • Muscle or body aches | <input type="checkbox"/> | <input type="checkbox"/> |
| • Headache | <input type="checkbox"/> | <input type="checkbox"/> |
| • New loss of taste or smell | <input type="checkbox"/> | <input type="checkbox"/> |
| • Sore Throat | <input type="checkbox"/> | <input type="checkbox"/> |
| • Congestion or runny nose | <input type="checkbox"/> | <input type="checkbox"/> |
| • Nausea or vomiting | <input type="checkbox"/> | <input type="checkbox"/> |
| • Diarrhea | <input type="checkbox"/> | <input type="checkbox"/> |

I hereby acknowledge that I have received a copy of this COVID-19 Daily Self Checklist. I understand that I am required to honestly and accurately complete this checklist for my child each day before sending my child to school.

Parent/Guardian Signature _____ DATE: _____

Student's Name _____