COVID-19 Health Assessment

To be completed daily and sent to school with your child.

Student Name:_____ Temperature:_____

Building: Date: _____

Please circle your response.

1. Have you traveled outside of the state/country in the past 2 weeks as per current PA travel restrictions? YES NO

2. Have you experienced any symptoms of COVID-19:

Fever 100.4 or greater	YES NO
Body chills	YES NO
Extreme fatigue	YES NO
Cough	YES NO
Runny nose/congestion	YES NO
Headache	YES NO
Nausea/vomiting/diarrhea	YES NO
Shortness of breath	YES NO
Pain or difficulty breathing	YES NO
Sore throat	YES NO
Muscle aches	YES NO
Loss of taste or smell	YES NO
Change in vision/eye drainage	YES NO

3. Do you suspect being exposed to someone who tested positive to COVID-19? YES NO

4. Have you or anyone in your household been diagnosed with COVID-19 in the past 2 weeks? YES NO

Parent/Guardian Signature_____