COVID-19 Daily Screening for Students/Staff

Name _____ Date _____

Parents/Guardians: Please complete this short check each morning and report your child's information per your school's reporting instructions.

Section 1: Symptoms

Any of the symptoms below could indicate a COVID-19 infection in children and may put your child at risk for spreading illness to others. Please note that this list does not include all possible symptoms and children with COVID-19 may experience any, all, or none of these symptoms. Please check your child daily for these symptoms:

Column A (2 or more)

☐	Chills, Fever
☐	Congestion or runny nose
☐	Fatigue or muscle aches
☐	Sore Throat
☐	Diarrhea, vomiting, or abdominal pain
☐	New onset of headache, especially with fever

Column B (one or more)

☐	Temperature 100.4F or higher
☐	Difficulty breathing, shortness of breath
☐	New Cough (if you have chronic allergic/asthmatic cough a change from baseline cough)
☐	New loss of taste or smell

If TWO OR MORE of the fields in Column A **are checked off** OR AT LEAST ONE field in column B **is checked off**, please keep your child home and notify the school for further instructions.

Section 2: Close Contact/Potential Exposure

Please verify if in the last 14 days:

☐	Your child has had close contact (within 6 feet of an infected person for 15 or more minutes during a 24-hour period) with a person with COVID-19
☐	Someone in your household is diagnosed with or being tested for COVID-19
☐	Your child has traveled to an area of high community transmission.

If **ANY of the fields in Section 2 are checked off**, your child should remain home for 14 days from the last date of exposure (if child is a close contact of a COVID-19 case) or date of return to New Jersey. Contact your child's healthcare provider or your local health department for further guidance.

Parent/Guardian Signature_____

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