

## Student Health Checklist

**FAMILIES:** You play an important part in keeping our schools open and students safe. Please review the questions daily and **KEEP CHILDREN HOME** if the answer is **YES** to any question.

YES OR NO, DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS?	YES	NO
Feeling feverish and/or having chills, with a temperature of 100.4°F or higher	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>
A new cough that is not due to another health condition	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty breathing	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea or vomiting	<input type="checkbox"/>	<input type="checkbox"/>
New onset of severe headache	<input type="checkbox"/>	<input type="checkbox"/>
New onset of loss of taste or smell	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a positive test for COVID-19 within the past 10 days?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been tested for COVID-19 because you were sick and are still waiting for the lab results?	<input type="checkbox"/>	<input type="checkbox"/>
In the past 14 days, have you been in close contact with someone who had any of the above COVID-19 symptoms or has tested positive for COVID-19? <b>CLOSE CONTACT IS:</b> <ul style="list-style-type: none"> <li>• Being less than 3 feet away in the classroom for 15 or more minutes during a 24-hour period, regardless of mask use.</li> <li>• Being less than 6 feet away while eating or outdoors for 15 minutes or more during a 24-hour period, regardless of mask use.</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>

***If you have any questions, please contact your local school.***