Covid Screening Questionnaire

Student Name: **Date:**

Parent Name:

Contact Number:

Email:

1. **Are you or your child experiencing any of the following symptoms:** **Y/N**

   a) Fever of 100.3 Degrees F/38 Degrees C or higher?
   b) Cough?
   c) Difficulty Breathing or Shortness of Breath?
   d) Fatigue or feeling of being generally unwell?

2. **In the last 14 days have you or your child travelled out of the country?**

3. **In the last 14 days have you or your child been in close contact with someone who has a confirmed or probable case of COVID-19?**

Signature:_____

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