COVID-19 Health Screening Questionnaire

1. Do you have any of these symptoms?

• Fever or chills • Cough • Shortness of breath or difficulty breathing • Fatigue • Muscle or body aches • Headache • Recent loss of taste or smell • Sore throat • Congestion • Nausea or vomiting • Diarrhea

2. Within the past 14 days, have you had contact with anyone that you know had COVID-19 or COVID-like symptoms?

3. Have you had a positive COVID-19 test in the past 10 days?

4. In the past 14 days, have you traveled anywhere on an airplane or been in close proximity to anyone who has been on an airplane?

As the parent/guardian of _____
I agree to ask my child the above questions before each SLOTTC training session. If the answer to any of the questions is a "yes", I agree to keep my child home until all responses can be a "no" answer.

_____
Parent/Guardian Name Printed

_____ _____
Parent/Guardian Signature **Date**