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?

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**