Child's Name_____ Date:_____

SonShine Entrance Checklist

Check off symptoms if present

[ ] fevers or chills	[ ] runny nose/congestion	[ ] nausea/vomiting
[ ] diarrhea	[ ] rash, incl. toes/fingers	[ ] shortness of breath
[ ] fatigue	[ ] cough	[ ] muscle or bodyache
[ ] headache	[ ] loss of taste/smell	[ ] sore throat

Have you had any known contact with a person confirmed or suspected to have COVID-19 in the past 14 days? Yes or No

Have you tested positive (or are you being tested) for COVID-19 through a diagnostic test in the past 14 days? Yes or No

Did your child sleep well last night? Yes or No

Eating and drinking normally? Yes or No

Any unusual events? Yes or No

Has your child received any medication this morning? Yes or No

What is the medication? Dose? Time given? _____

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