# COVID-19 SCREENING QUESTIONNAIRE

The safety of our employees, families, and students is our overriding priority. As the coronavirus (COVID-19) pandemic continues, we are monitoring the situation closely and following the guidance from the Centers for Disease Control and Prevention, Bright From The Start, and local health authorities. In order to prevent the spread of the coronavirus and reduce the potential risk of exposure to our workforce, we are asking everyone to complete and submit this questionnaire prior to dropping your child off at school. Please do not leave the site until your responses have been reviewed and your entry has been approved.

**Please respond to each of the following questions truthfully and to the best of your ability.** Your participation is important to help us take precautionary measures to protect your children, you, and our employees

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| Child Name: Drop Off Persons Name: |
| Classroom: |

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| --- | --- | --- | --- |
| **Representations** | | | |
| 1 | Are you or your child currently experiencing, or have you experienced in the past 14 days, any of the following symptoms? (***Drop off persons, please take temp at home before dropping off)***  Yes ☐ No ☐ Fever (100.4° F/37.8° C or greater as measured by an oral thermometer) Yes ☐ No ☐ Cough  Yes ☐ No ☐ Shortness of breath or difficulty breathing Yes ☐ No ☐ Sore throat  Yes ☐ No ☐ New loss of taste or smell Yes ☐ No ☐ Chills  Yes ☐ No ☐ Head or muscle aches  Yes ☐ No ☐ Nausea, diarrhea, vomiting | | |
| 2 | In the past 14 days, have you or your child been in close proximity to anyone who was experiencing any of the above symptoms or has experienced any of the above symptoms since your contact?  Yes ☐ No☐ | | |
| 3 | In the past 14 days, have you or your child been in close proximity to anyone who has tested positive for COVID-19?  Yes ☐ No☐ | | |
| 4 | Have you or your child been tested for COVID-19 and are waiting to receive test results?  Yes ☐ No☐ | | |
| 5 | | Have you or your child tested positive for COVID-19, or are you presumptively positive for COVID-19 based on your health care provider’s assessment of your symptoms?  Yes ☐ No☐ |

**I hereby certify that the responses provided above are true and accurate to the best of my knowledge.**

Signature: Date:

Note: The information collected on this form will be used to determine only whether you may be infected with COVID-19. The information on this form will be maintained as confidential. Any questions should be directed to the management team