COVID-19 Screening Questionnaire

1. Do you have any of the following symptoms:

- A fever of 100.4 degrees Fahrenheit or higher
- A cough
- Shortness of breath or difficulty breathing
- Body aches, headache, new loss of taste or smell, sore throat?

Yes No

2. Have you traveled in the past 14 days to regions affected by COVID-19?

Yes No

3. Have you been in close contact with anyone who a has a <u>confirmed</u> COVID-19 diagnosis?

Yes No

All students answered "No" to the questions above.

Date	Class	Phone Number	Print Name	Signature	Comments