Child's Name: _____ Week of: _____

Today, or in the past 24 hours, have you or any household members had any of the following symptoms?

- Fever (temperature of 100 degrees or higher), cough, sore throat, difficulty breathing, diarrhea, nausea, vomiting, headache, new loss of smell/taste, new muscle aches, or any other sign of illness?

In the past 14 days, have you had close contact with a person known to be infected with the novel coronavirus?

YES NO

Parent/Guardian Signature: _____ Date: _____

YES NO

Parent/Guardian Signature: _____ Date: _____

YES NO

Parent/Guardian Signature: _____ Date: _____

YES NO

Parent/Guardian Signature: _____ Date: _____

YES NO

Parent/Guardian Signature: _____ Date: _____