SJB Weekly Symptom Screening Checklist
Adult Reporting for Student
Return on Monday to Homeroom Teacher

Name _____ Grade ____

Parent Signature _____

Since this child was last at school, has s/he been diagnosed with COVID-19?

- ☐ YES
- ☐ NO

Has this child had close contact (within 6 feet for at least 10 minutes) with someone diagnosed with COVID-19 in the last 14 days, or has any health department or health care provider been in contact with you and advised you to quarantine?

- ☐ YES
- ☐ NO

Does this child have any of the symptoms below?

- ☐ Fever (100.1 or higher)
- ☐ Cough
- ☐ Shortness of breath or difficulty breathing
- ☐ Fatigue
- ☐ Muscle or body aches
- ☐ Headache
- ☐ New loss of taste or smell
- ☐ Sore Throat
- ☐ Congestion or runny nose
- ☐ Nausea or vomiting
- ☐ Diarrhea

If a child has any of these symptoms, s/he should stay home, stay away from other people, and the family should contact the child's healthcare provider.

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