Child's Name ____ Start Date ________________________

Pre-School Health Screening (14 day)

Dear School families,

In an effort to minimize illness at school, we ask that you complete a daily assessment beginning 14 days prior to the start of your child's session. The best school session starts with healthy children and this begins at home. Please bring this completed form to school on the first day of your child's session.

Please indicate if (child's name) ____________________ has any of the following symptoms prior to school and record a temperature daily. If any temperature exceeds 100.0 degrees or symptoms are present, please be evaluated by a licensed Doctor and contact school for further guidance.

Symptoms:

- Cough
- Shortness of breath or difficulty breathing
- Fever
- Chills
- Muscle Pain
- Sore throat
- New loss of taste or smell
- Nausea
- Vomitting
- Diarrhea

Please initial each line

1. My child has not been around anyone with any of the listed symptoms or diagnosis of COVID-19 in the 14 days before the start of school. Initial _______
2. No one in our household has been sick in the 14 days prior to school. Initial _______
3. My child has not traveled by air or traveled out of state in the 14 days prior to school. Initial _______
4. My child has adhered to our state's guidelines regarding COVID-19. Initial _______

Start date of temperature/ symptom screening:

____

Day	**14**	**13**	**12**	**11**	**10**	**9**	**8**
Temp/Symp							
Day	**7**	**6**	**5**	**4**	**3**	**2**	**1**
Temp/Symp							

My signature indicates that I completed this health screening daily for 14 days prior to school and to the best of my ability. I understand that arriving at school healthy is vital to a healthy school.

Parent/Guardian Signature ____Date _______________

Child's Name ____