

Dumont School District COVID-19 Daily Pre-Screening Questions

Student Name: _____ Date: _____ Phone #: _____ School _____

Any of the symptoms below could indicate a COVID-19 infection and may put you at risk for spreading illness to others. This list does not include all possible symptoms and it should be noted that individuals with COVID-19 may experience any, all, or none of these symptoms. **Parents, please check your child for the following symptoms daily prior to coming to school. If you answer YES to any of the following symptoms, please keep your child home and contact your school nurse or building administrator for further instruction.**

Symptoms	Please Circle One	
1. Fever ($\geq 100.4^{\circ}\text{F}$)	YES	NO
2. Cough, shortness of breath, or difficulty breathing	YES	NO
3. Sore Throat	YES	NO
4. Chills	YES	NO
5. Muscle aches (myalgia)	YES	NO
6. Rigors (shivers)	YES	NO
7. Fatigue (extreme tiredness)	YES	NO
8. Headache	YES	NO
9. Congestion or Runny Nose	YES	NO
10. New loss of taste or smell	YES	NO
11. Abdominal pain, nausea, vomiting or diarrhea	YES	NO
12. Have you had close contact (within 6 feet of an infected person for at least 10 minutes) with someone who is currently sick?	YES	NO
13. Have you been diagnosed with COVID-19 in the past three weeks or do you have reason to believe that you have had close contact (within 6 feet for at least 10 minutes) with a person with confirmed COVID-19?	YES	NO
14. Have you traveled to a state or area with high community transmission in the last 14 days?	YES	NO
15. Did you take any fever reducing medicine this morning?	YES	NO
16. What is your temperature this morning? _____		

I certify that the responses I provided to the questions above are all true.

Individual's Signature: _____

9/14/20