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 (≥ 100.4°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