HEALTH AND SAFETY COVID-19 QUESTIONNAIRE

The completed questionnaire is necessary for every in-person appointment.

Date: _____ Student's Temperature: _____

Name of student: _____
(please print)

Name of Parent: _____
(please print)

Location (circle one):

High School	Eagle Academy	Alder MS	Fernwood MS
Miller School	Davenport Primary	Davenport Elem	Slaybaugh Primary
Slaybaugh Elem	Swift School		

		(circle one)
1. Was fever reducing medication administered to your child today?	Yes	No
2. Have you or your child been exposed to anyone, within the last 14 days, who was confirmed to have tested positive for Covid 19?	Yes	No
3. Does your child have any of the following symptoms (at least 1) not associated with existing medical conditions? Cough, Shortness of Breath, Difficulty Breathing, New Loss of Smell, New Loss of Taste.	Yes	No
4. Do you or your child have any of the following symptoms (at least 2): Chills, Shivers, Muscle Aches, Headache, Sore Throat, Nausea/Vomiting, Diarrhea, Fatigue, Runny Nose/Congestion?	Yes	No

By signing this questionnaire, I certify that the above information is true.

_____ _____
Parent Signature Date

_____ _____
Signature of Staff Member (Witness) Date