

RNESU, Daily Health Screening Form

Date: _____

Student name(s): _____

I attest that my child(ren) DO NOT have ANY of the following symptoms:

Cough, shortness of breath, new loss of taste or smell, fever, sore throat, nausea, vomiting, diarrhea, muscle aches, headache, unusual or excessive fatigue, or runny nose AND has not taken medication for the purpose of any of the above listed symptoms in the past 24 hours; unless otherwise specifically addressed and cleared for re-entry to school by the School Nurse.

I attest that my child(ren) has not traveled anywhere that is restricted by the VT Dept of Health in the past 14 days, used public transportation or been in contact with anyone that has tested positive for COVID19.

Signature of parent/guardian: _____

This section is for staff only, to be completed at screening upon arrival:

Temperature within normal limits. Note actual if elevated above 100°F and notify nurse: _____

*Call/radio nurse for questions/concerns prior to admittance.

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