RNESU HEALTH SCREENING FORM

NAME:_____ DATE:_____

Please carefully read and answer the following daily COVID screening questions about your child:

	Yes	No
Cough or shortness of breath? ***For students with a chronic cough related to allergies or asthma, has there been a change in their usual cough?**	If yes, stay home.	
Fever within the past 24 hours?	If yes, stay home.	
New loss of taste or smell?	If yes, stay home.	
ANY of the following symptoms: Sore throat, diarrhea, muscle aches, headache, fatigue, runny nose.	If yes, stay home.	
Has your student taken any fever reducing medication in the past 24 hours such as Tylenol (acetaminophen), Motrin/Advil (ibuprofen), or other cough/cold remedies for any of the symptoms listed above?	If yes, stay home.	
Has your child had close contact (within 6 feet of an infected person for at least 15 minutes) with a person with confirmed COVID-19?	If yes, stay home.	
Has your child traveled to or lived in an area where the local, Tribal, territorial, or state health department is reporting large numbers of COVID-19 cases?	If yes, stay home until the 14 quarantine is complete, without illness.	

***If ANY questions are answered with a yes, contact School Nurse.**

Parent/Guardian signature:_____ Date:_____

Temperature will be checked by screening staff upon arrival, please leave the following question blank:	
Temperature: 100.4 °F or higher may not attend school, temp below 97.0 or between 100.0-100.3 °F will be evaluated by the nurse before entry.	_____ □