COVID-19 Daily Screening for Students/Staff Name

Name ____________________________ Date ___________

Parents/Guardians and Staff: Please complete this short check each morning. If you see any symptoms or answer YES to any question in section 2, you must contact the attendance office.

Section 1: Symptoms

Any of the symptoms below could indicate a COVID-19 infection in children and may put your child at risk for spreading illness to others. Please note that this list does not include all possible symptoms and children with COVID-19 may experience any, all, or none of these symptoms. Please check your child daily for these symptoms:

Your child should not attend school if they have a FEVER (temp of 100 or more).

Column A

Fever (measured or subjective)
Chills
Rigors (shivers)
Myalgia (muscle aches)
Headache
Sore Throat
Nausea or Vomiting
Diarrhea
Fatigue
Congestion or runny nose

Column B

Cough
Shortness of breath
Difficulty breathing
New loss of smell
New loss of taste

If TWO OR MORE of the fields in Column A are checked off OR AT LEAST ONE field in column B is checked off, please keep your child home and notify the school for further instructions.

Section 2: Close Contact/Potential Exposure

Please verify if:

Your child has had close contact (within 6 feet of an infected person for at least 10 minutes) with a person with confirmed COVID-19.

Someone in your household is diagnosed with COVID-19.

Your child has traveled to an area of high community transmission.

If ANY of the fields in Section 2 are checked off, your child should remain home for 14 days from the last date of exposure (if child is a close contact of a confirmed COVID-19 case) or date of return to New Jersey.

Contact your child's provider or your local health department for further guidance.