DATE: ____/_____ /2020

CHILDS NAME:

_____

Has anyone in your family been exposed to anyone suspected or confirmed to have Covid-19?

_____ Yes _____ No

- ☐ Cough or Shortness of Breath
- ☐ Headache
- ☐ Sore Throat
- ☐ Chills or Shaking
- ☐ Muscle Aches
- ☐ Diarrhea
- ☐ Nausea/Vomiting
- ☐ Runny Nose
- ☐ Abdominal Pain
- ☐ Loss of taste or smell
- ☐ Covid Toe (red/purple swelling)

My child's Temperature this morning is _____

Parent Signature _____

DATE: ____/_____ /2020

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