Student Name: ____

Parent/Guardian Name: ____

Parent/Guardian Signature: ____________________________________

Date: ________________________ **PHONE NUMBER:** _______________________

COVID-19 Health Screening Questions to be completed daily by a parent/guardian, staff member or essential visitor

Staff and Students should remain at home if any of the responses are 'YES"

Essential visitors will not be permitted into FCPS facilities if any of the responses are 'YES'

YES or NO, since your last day of school/work/visitation have you had any of the following symptoms?	Yes	No
Feeling feverish and/or having chills –documented temperature of 100.4°F or higher?	☐	☐
Has there been any use of fever reducing medication within the last 24 hours?	☐	☐
A new cough that is not due to another health condition?	☐	☐
Nasal congestion or runny nose	☐	☐
New shortness of breath or difficulty breathing that is not due to another health condition?	☐	☐
New chills that are not due to another health condition?	☐	☐
A new sore throat that is not due to another health condition?	☐	☐
New muscle aches that are not due to another health condition, or that may have been caused by a specific activity (such as physical exercise)?	☐	☐
Fatigue (more tired than usual)?	☐	☐
Headache?	☐	☐
A new loss of taste or smell?	☐	☐
Abdominal pain, diarrhea, nausea or vomiting?	☐	☐
New onset of poor appetite or poor feeding?	☐	☐
Have you had a positive test for the virus that causes COVID-19 disease within the past 10 days?	☐	☐
Were you currently tested for COVID-19 because you were sick and are still waiting for the lab results?	☐	☐
In the past 14 days, have you had close contact (within about 6 feet for 15 minutes or more) with someone with suspected or confirmed COVID-19?	☐	☐