Child Health & Wellness Check

Name: _____ **Date:** _____|_____|_____

Classroom/Teacher(s) Name: _____

Printed name of person conducting the test:_____

Signature of Person conducting the check:_____

*Please, check the appropriate box

	Yes	No	Comments
Has any fever reducing medication been administered to you/your child today?			
Are you or any of your household members experiencing one (1) of the following CDC - COVID-19 symptoms?			
Cough			
Shortness of breath or Trouble breathing			
New loss taste/smell			
Are you or any of your household members experiencing at least two (2) of the following symptoms?			
Sore Throat			
Shivers/ Chills			
Congestion/Runny Nose			
Headache / muscle pain			
Have you been in close contact with anyone who is experiencing COVID-19 like symptoms and is awaiting results of a COVID-19 test?			
Have you been exposed to anyone who has tested positive for COVID-19?			
Have you recently traveled to an area of high community transmission? _____			

Current Temperature: _____ (temperature needs to be less than 100.4 degrees)

* Students will need to be excluded/sent home immediately if they display these symptoms or until they receive an alternate diagnosis from a healthcare provider or a negative COVID-19 test result