RNESU HEALTH SCREENING FORM

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

NAME(S):_____ DATE:_____

Please write in each child's name above the "no" column. (If there are any children in the family with a "yes" to any question, they should not attend school, please contact the school nurse.)				
	Yes	No	No	No
Cough or shortness of breath? ***For students with a chronic cough related to allergies or asthma, has there been a change i their usual symptoms?**	If yes, stay home. Contact doctor.			
New loss of taste or smell?	If yes, stay home. Contact doctor.			
Fever within the past 24 hours?	If yes, stay home.			
ANY of the following symptoms: Sore throat, nausea, vomiting, 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 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 a yellow or red zone according to the Vermont Department of Health travel page map? Please visit this page for more information, https://accd.vermont.gov/covid-19/restart/cross-state-travel	If yes, stay home until the 14 quarantine is complete, without illness.			

***If ANY questions are answered with a yes, do not come to school, contact School Nurse.**

Parent/Guardian signature:_____ Date:_____

Temperature will be checked by screening staff upon arrival, please leave the following question blank:	**°F,** complete columns to match the names listed above		
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.			

Staff initials:_____