

Daily COVID-19 Health Screening

Community *

Child's First Name Last Initial (MariaM)

Does your child have any of the following symptoms if the symptom is of greater intensity or frequency than what is normally experienced? Check All That Apply *

- Cough
- Fever of 100.0 or higher
- Shortness of Breath
- Sore throat
- Runny nose or congestion
- Gastrointestinal symptoms (diarrhea, nausea, vomiting)
- Chills or repeated shaking with chills
- New loss of taste or smell
- Muscle aches
- Headache
- No symptoms

Child's temperature today: *

Has your child had contact with someone in the previous 14 days with a confirmed case of COVID-19?

- Yes
- No

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