Child's Full Name:_____ Date:_____

In the past 24 hours, has your child experienced fever? (temperature over 100.4° F without having taken any fever-reducing medications)

- ◯ Yes
- ◯ No

In the past 24 hours, has your child experienced chronic congestion or an uncontrolled runny nose?

- ◯ Yes
- ◯ No

In the past 24 hours, has your child experienced a headache?

- ◯ Yes
- ◯ No

In the past 24 hours, has your child experienced nausea or a significant loss of appetite?

- ◯ Yes
- ◯ No

In the past 24 hours, has your child experienced cough?

- ◯ Yes
- ◯ No

In the past 24 hours, has your child experienced shortness of breath?

- ◯ Yes
- ◯ No

In the past 24 hours, has your child experienced vomiting or diarrhea?

- ◯ Yes
- ◯ No

In the past 24 hours, has your child experienced a sore throat?

- ◯ Yes
- ◯ No

In the past 24 hours, has your child experienced loss of taste or smell?

- ◯ Yes
- ◯ No

Has anyone in the family been in self isolation or quarantine in the last two weeks?

- ◯ Yes
- ◯ No

Has anyone in the family tested positive, or had close contact with anyone who has tested positive for COVID-19 or had symptoms of COVID-19?

- ◯ Yes
- ◯ No

Has anyone in the family traveled outside the 6 county service area?

- ◯ Yes
- ◯ No

What is your child’s temperature?

_____