

Child Health Screening Form

Date: _____ Child Care Program: _____

Please answer the following questions to the best of your ability:

Child's Name	Does your child have any symptoms of COVID-19 listed below? Y or N	Has your child or anyone in the household traveled outside of ME, NH, NY, CT, NJ or VT in the past month? Y or N	Has your child come into contact with anyone who has tested positive with COVID-19? Y or N	Is anyone in your child's household experiencing signs of illness? Y or N	Child's temperature	Parent signature (agreeing to the information)	Staff person initials

Symptoms of COVID-19: Cough, Shortness of breath or difficulty breathing, Fever, Chills, Repeated shaking with chills, Muscle or body aches, Headache, Sore throat, New loss of taste or smell, Congestion or runny nose, Nausea or vomiting, Diarrhea