STUDENT'S NAME: _____ **GRADE:** _____

Daily Screening Form **Date:** _____ ***For Screener Use Only: Temp Checked:** ____

Revised 8/27/2020 ***Temperature if 100 or above:*** _____

If your child has any of the following symptoms or answers YES to any of the following, please do not send them to school.

____ **NO to all of the below.**

Symptoms:
____ Has a temperature above 100 degrees Fahrenheit
____ Sore throat
____ New cough that causes difficulty breathing (for students with chronic allergic / asthmatic cough, a change in their cough from baseline)
____ Diarrhea, vomiting, or abdominal pain
____ New onset of severe headache, especially with a fever

Close Contact / Potential Exposure:
____ Had close contact with a person with confirmed COVID-19 (within 6 feet of an infected person for at least 10 minutes)
____ Have been asked by the Randolph County Health Department to Isolate due to potential exposure

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