COVID-19 Health Screening **DATE:**_____

Name (1st):_____ **Temp Reading**:_____

Name (2nd):_____ **Temp Reading**:_____

Name: (3rd) _____ **Temp Reading**:_____

Does your child(ren) have any of the following symptoms (please check)?

	1st	2nd	3rd
Dry Cough:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Shortness of Breath:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Sore Throat:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Loss of taste or smell:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Nasal Congestion:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

***REMINDER: YOUR STUDENT(S) MUST HAVE MASKS ON UPON EXITING THE VEHICLE.**