

| HCS Elementary Screening Form   |   |   |   |  |   |   |
|---|---|---|---|--|---|---|
| <i>If YES to ANY, child should stay home. They can return to school after their symptoms subside and at least 24 hours of no fever without medications.</i> | <b>Since last here, has your child had any of these symptoms?</b> | Y | N | Since last here, is your child waiting for a <b>COVID-19 test result</b> , been <b>diagnosed</b> with COVID-19, or been <b>instructed</b> by any health care provider or the health department to isolate or quarantine? <i>If YES, keep child at home until a negative test result has been received or until advised to be released from quarantine by a health care provider.</i> | Y | N |
|   | new cough   |   |   |  |   |   |
|   | difficulty breathing  |   |   | Since last here, has your child had <b>close contact</b> (within 6 feet for at least 15 minutes) with anyone diagnosed with COVID-19, or suspected of having COVID-19 (i.e. tested due to symptoms)? <i>If YES, keep child at home until they have completed quarantine for the amount of time recommended by the CDC or health care provider.</i>                                   |   |   |
|   | fever of 100.4 or higher  |   |   |  |   |   |
|   | sore throat   |   |   |  |   |   |
|   | diarrhea or vomiting  |   |   |  |   |   |
|   | loss of taste or smell  |   |   |  |   |   |
| new onset of severe headache (esp. with fever)  |   |   |   |  |   |   |
| <b>What is your child's temperature this morning?</b><br><small>Temperatures from multiple children can be separated by commas, oldest to youngest.</small> |   |   |   |  |   |   |

Child's Name(s) \_\_\_\_\_ Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

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