CVSD Student Symptom Verification REV 9/8/20

Does your student have any of the following symptoms?

- Fever of 100.4°F or higher (or a sense of having a fever)
- Chills
- · Shortness of breath or difficulty breathing
- Fatigue
- · Muscle or body aches

Yes No

- Headache
- · New loss of taste or smell
- · Sore throat
- Cough
- · Congestion or runny nose
- Nausea or vomiting
- Diarrhea

Today's Date: _

Today's Date: ___

____ Grade: ___

- Does anyone in your household have any of the above symptoms?
- Has your student been in close contact (within 6 feet for 15 minutes) with someone who has confirmed COVID-19 in the last 14 days?
- · Has a public health or medical professional told your child to selfmonitor, self-isolate or self-quarantine because of concerns about COVID-19 infection, within the past 14 days?
- Has your student tested positive for COVID-19 in the past 10 days?
- Has your student had any medication to reduce a fever before coming to school?

Did you answer 'Yes' to any of the above questions?

Student Name:		
School:	Grade:	
Parent/Guardian Signature:		
School Temperature Check: ☐No concerns ☐Recheck ☐Send h	iome:	
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Did you answer 'Yes' to any of the above questions?

□No concerns □Recheck □Send home:_

Yes No

Parent/Guardian Signature:

School Temperature Check:

Student Name: __

School

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