Child's Name: ______________________________

Teacher's Name: ____________________________

Today's Date: ______________________________

Recorded Temperature: ______________________

YES NO Has your child received fever reducing medication, such as Tylenol or Motrin, in the last 24 hours?

YES NO Since your child was last at school, have they experienced any of the following: fever, cough, shortness of breath, chills, sore throat, body aches, loss of taste or smell?

YES NO In the last 14 days, has your child had a pending or positive test for COVID-19; or has your child had close contact with someone with confirmed or suspected COVID-19?

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