Health Screening Assessment, COVID-19 Supplemental Questionnaire

These questions must be answered if person answers “yes” to any questions on the COVID-19 Screening Assessment.

Person’s Name: _____ Date: _____

Child’s Name: _____ DOB: _____

Do you have any of the following symptoms? (please check all that apply)

_____Fever or Chills

_____Cough

_____Shortness of Breath or Difficulty Breathing

_____Fatigue

_____Muscle or Body Aches

_____Headache

_____New Loss of Taste or Smell

_____Sore Throat

_____Congestion or Runny Nose

_____Nausea or Vomiting

_____Diarrhea

_____None of the Above

I hereby Affirm that to the best of my knowledge, all answers above are true.

_____ _____ _____

Name Signature Date

This form will be maintained with the health assessment in the child’s record.

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