COVID-19 Weekly Questionnaire

Date: _____ _____

Name of Child: _____

Yes No 1. Have you had contact with anyone that has been confirmed positive COVID-19 or that has been quarantined in the last 14 days?

Yes No 2. Have you tested positive or been quarantined with COVID-19 in the last 14 days?

Yes No 3. Have you had any **one** of these symptoms: Fever greater than 100.4, difficulty breathing, new or worsening cough, loss of smell or taste

Yes No And **any two** of the following: Sore throat, muscle or body aches, chills, fatigue, headache, congestion or runny nose, diarrhea, nausea or vomiting.

Signature of Parent _____