Child(ren) Names: _____

1. Has any fever reducing medication been administered? _____

2. Is your child exhibiting at least 2 of the following: chills, shivers, muscle aches, headache, sore throat, nausea/vomiting, diarrhea, fatigue, congestion/runny nose? _____

3. Is your child exhibiting at least 1 of the following: cough, shortness of breath, difficulty breathing, new loss of taste or smell? _____

4. Has your child had close contact (within 6 feet for at least 10 minutes) with a person with confirmed COVID-19 in the past 14 days? _____

5. Is there someone in the household that has symptoms of COVID-19 or is diagnosed with COVID-19? _____

6. Has your child traveled to an Area of High Community Transmission? _____

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