STUDENT HEALTH SURVEY

DATE:________________________

STUDENT NAME:____________________________________

Please circle YES or NO to the following questions:

- Has the adult or child been exposed to a person with a positive case of COVID-19 in the past 14 days? **YES or NO**
- Has the adult or child been exposed to a person with a presumptive case of COVID-19 in the past 14 days? **YES or NO**
- Is the adult or child experiencing unusual cough, shortness of breath, fever, **or new loss of taste or smell.** (unusual cough means something not normal for this person-e.g., allergies, asthma) **YES or NO**
- Does the child or adult have symptoms of diarrhea, vomiting, headache, sore throat or rash? **YES or NO**

PASS or FAIL

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