Child Health Screening Form

Child's name:	
Date:	
I, or my child, have not been feverish or measured temperature of 100 or greater since last in the child care site? Or in past 14 days, If new or returning from absence?	I, or my child, have not exhibited symptoms (ex. Sore throat, nasal congestion, runny nose, new or worsening cough, shortness of breath, fatigue, headaches, body aches, nausea, vomiting, diarrhea, loss of taste or smell) since yesterday? Or in the past 14 days, if new or returning from absence?
I, or my child, have not had close, prolonged contact with anyone known to have covid-19 or who has symptoms of Covid-19(ex. Sore throat, nasal congestion, runny nose, new or worsening cough, shortness of breath, fatigue, headaches, body aches, nausea, vomiting, diarrhea, loss of taste or smell) since yesterday? Or in the past 14 days, if new or returning from absence?	PLEASE INITIAL THAT ALL 3 STATEMENTS ARE TRUE
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