Daily Log of Child Entry Health Screening and Attendance

Complete the checklist below for your child prior to entering or being admitted to the school each day

Student Name: _____ **Date:** _____

Parent Name (Print): _____ **Signature:** _____

Temperature upon arrival: _____

	YES	NO
Have you given your **CHILD** any fever reducing medication?	☐	☐
Has your **CHILD** had any close contact with anyone diagnosed with COVID-19 in the past 14 days?	☐	☐
Does your **CHILD** have a cough, shortness of breath, trouble breathing?	☐	☐
Does your **CHILD** have a headache, fever, muscle pain, chills, repeated shaking with chills, new loss of taste or smell?	☐	☐
Does any **HOUSEHOLD MEMBER** have a cough, shortness of breath, trouble breathing?	☐	☐
Does any **HOUSEHOLD MEMBER** have a headache, fever, muscle pain, chills, repeated shaking and chills, new loss of taste or smell?	☐	☐

Daily Log of Child Entry Health Screening and Attendance

Complete the checklist below for your child prior to entering or being admitted to the school each day

Student Name: _____ **Date:** _____

Parent Name (Print): _____ **Signature:** _____

Temperature upon arrival: _____

	YES	NO
Have you given your **CHILD** any fever reducing medication?	☐	☐
Has your **CHILD** had any close contact with anyone diagnosed with COVID-19 in the past 14 days?	☐	☐
Does your **CHILD** have a cough, shortness of breath, trouble breathing?	☐	☐
Does your **CHILD** have a headache, fever, muscle pain, chills, repeated shaking with chills, new loss of taste or smell?	☐	☐
Does any **HOUSEHOLD MEMBER** have a cough, shortness of breath, trouble breathing?	☐	☐
Does any **HOUSEHOLD MEMBER** have a headache, fever, muscle pain, chills, repeated shaking and chills, new loss of taste or smell?	☐	☐