Visitor / Parent / Staff

Questionnaire for Parents & Staff	Name:	Date:
Do you or a family member had any respiratory symptoms (sore throat or cough)	○ YES	○ NO
Have you experienced a fever within the last 24-48 hours?	○ YES	○ NO
Do you or any of your relatives experienced a fever within the last 24-48 hours?	○ YES	○ NO
Have you or a family member travelled outside the United States within the past 14 days?	○ YES	○ NO
Are you currently working in the healthcare field?	○ YES	○ NO
Have you been in contact with anyone who has received a positive Coronavirus test?	○ YES	○ NO

Parent for Child(ren)

Questionnaire for Child		Child's Name: __________ Week Of: ___________		
	Monday	Tuesday	Wednesday	Thursday	Friday
Has your child had any respiratory symptoms or complained of a sore throat or cough?	YES NO	YES NO	YES NO	YES NO	YES NO
Has your child experienced a fever within the last 24-48 hours?	YES NO	YES NO	YES NO	YES NO	YES NO
Do you or your child have any relatives who have experienced a fever within the last 24-48 hours?	YES NO	YES NO	YES NO	YES NO	YES NO
Have you, your child or a family member travelled outside the United States within the past 14 days?	YES NO	YES NO	YES NO	YES NO	YES NO
Have you or your child been in contact with anyone who has received a positive Coronavirus test?	YES NO	YES NO	YES NO	YES NO	YES NO
Teacher Initials					