COVID-19 Daily Screening

Student Name:_____ Date: _____

Section 1: Symptoms **Your Temperature: _____**

Any of the symptoms below could indicate a COVID-19 infection and may put others at risk. Please note that this list does not include all possible symptoms and people with COVID-19 may experience any, all, or none of these symptoms.

Column A			Column B	
☐	Fever (measured or subjective)		☐	Cough
☐	Chills		☐	Shortness of Breath
☐	Rigors		☐	Difficulty Breathing
☐	Muscle Aches		☐	New Loss of Smell
☐	Headache		☐	New Loss of Taste
☐	Sore Throat			
☐	Nausea or Vomiting			
☐	Diarrhea			
☐	Fatigue			
☐	Congestion or Runny Nose			

If **TWO OR MORE of the fields in Column A are checked off OR AT LEAST ONE field in column B** is checked off, please stay home and notify the program director for further instructions.

Section 2: Close Contact/Potential Exposure

Please verify if during the past 14 days:

☐	You have had close contact (within 6 feet of an infected person for 15 or more minutes during a 24 hr period) with a person with COVID-19
☐	Someone in your household is sick and is being evaluated, diagnosed or being tested for COVID-19
☐	You have traveled to an area of high community transmission. NJ Travel Advisory List CDC Travel Notices

If **ANY** of the fields in Section 2 are checked off, you may NOT participate in-person. Close/Household contact requires a 10 day quarantine. Travel requires a 10 day quarantine after returning home.