Appendix 1: Sample COVID-19 School Screening Tool

<School Letterhead in Header>

COVID-19 Daily Screening for Students

Name _____ Date _____

Parents/Guardians: Please complete this short check each morning and report your child's information per your school's reporting instructions.

Section 1: Symptoms

Any of the symptoms below could indicate a COVID-19 infection in children and may put your child at risk for spreading illness to others. Please note that this list does not include all possible symptoms and children with COVID-19 may experience any, all, or none of these symptoms. Please check your child daily for these symptoms:

Column A

☐	Fever (measured or subjective)
☐	Chills
☐	Rigors (shivers)
☐	Myalgia (muscle aches)
☐	Headache
☐	Sore Throat
☐	Nausea or Vomiting
☐	Diarrhea
☐	Fatigue
☐	Congestion or runny nose

Column B

☐	Cough
☐	Shortness of Breath
☐	Difficulty Breathing
☐	New loss of smell
☐	New loss of taste

Students who are sick (e.g. fever, vomiting, diarrhea) should **not** attend school in-person. 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 keep your child home and notify the school for further instructions.

Section 2: Close Contact/Potential Exposure

Please verify if in the last 14days:

☐	Your child has had close contact (within 6 feet of an infected person for 15 or more minutes during a 24-hour period) with a person with COVID-19
☐	Someone in your household is diagnosed with or being tested for COVID-19
☐	Your child has traveled from any U.S. state or territory outside of New York, Connecticut, Pennsylvania, and Delaware and is not otherwise exempt from quarantine under the [link DOH travel restrictions]

If **ANY of the fields in Section 2 are checked off,** contact your school for exclusion recommendations. Contact your child's healthcare provider or your local health department for further guidance.

10/18/21

3/31/21