# Health Questionnaire

1) Have you or anyone in your immediate family had a fever of 100 or above in the last 48 hours without fever reducer? ☐ **Yes** ☐ **No**

2) Have you or anyone in your immediate family had symptoms of a respiratory infection, a cough, shortness of breath, sore throat, chills, muscle pain, headache, diarrhea or a loss of taste/smell? ☐ **Yes** ☐ **No**

3) In the previous 14 days have you or anyone in your immediate family had contact with someone with a confirmed diagnosis of COVID-19; is under investigation for COVID-19; or is ill with respiratory illness? ☐ **Yes** ☐ **No**

4) In the previous 14 days have you or anyone in your immediate family travelled internationally to countries with widespread, sustained community transmission? ☐ **Yes** ☐ **No**

Child's Name: _____ Temp: _____

Child's Name: _____ Temp: _____

Parent Signature: _____ Date: _____

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**Staff Only** **Printed Name: _____ Temp: _____**

**Signature: _____ Date: _____**


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