 **COVID-19 Daily Health Screening Questions**

If you answered YES to any of these questions, you must stay

home and notify the school.

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| Do you have a **fever** (100 degrees or higher or feel feverish if no  thermometer) without having taken fever-reducing medicine? |  |
| Do you have a cough? |  |
| Do you have a new **loss of taste or smell**? |  |
| Do you have a **sore throat**? |  |
| Do you have **muscle aches**? |  |
| Do you have **chills**? |  |
| Do you have **shortness of breath**? |  |
| Do you have a new or unusual **headache**? |  |
| Have you experienced new onset of **gastrointestinal symptoms**,  such as nausea, vomiting, diarrhea, or loss of appetite? |  |
| Have you, or anyone you have been in close contact with, **been**  **diagnosed with Covid-19 or placed in quarantine** for possible  exposure to Covid-19 within the last two weeks? |  |
| Have you been asked to **self-isolate or quarantine** by a medical  professional or a local public health official within the last two  weeks? |  |
| Have you **travelled within the last 14 days** to a location which  requires a 14 day self-quarantine according to Executive Order  No. 7BBB? |  |