VCS Daily Home Screening for Students

Please complete this short check each morning before your child leaves for school. This form must be turned in at the morning drop-off screening in order for your child to participate with in-person instruction.

SECTION 1: Symptoms

Is your child experiencing any of these COVID-19 symptoms?

Temperature 100.4 degrees Fahrenheit or higher	**Yes/No**
Sore throat	**Yes/No**
Cough/difficulty breathing (for students with chronic allergic/asthmatic cough, a change in their cough from baseline)	**Yes/No**
Diarrhea, vomiting, or abdominal pain	**Yes/No**
Headache	**Yes/No**
Body aches	**Yes/No**
Loss of taste or smell	**Yes/No**

SECTION 2: Close Contact/Potential Exposure

Do any of the following risk factors apply to you?

Had close contact (within 6 feet of an infected person for at least 15 minutes) with a person with confirmed COVID-19 or possible COVID-19 exposure. **Yes/No**

If you checked YES to any of the above questions you may have risk factors for COVID-19. Please DO NOT send your child to school for in-person instruction. Please contact your primary care provider to seek guidance before you attend school.

Parent/Guardian Name____

Parent/GuardianSignature____

Student Name____

Date______________