ST. ROSE OF LIMA SCHOOL

STUDENT WEEKLY HOME SCREENING QUESTIONS

Date:_______________ Name:____________________

Temperature was checked this morning & it was less than 100 F.

In the last 14 days, my child **HAS NOT:**

- ❑ **Experienced ANY of the following symptoms of COVID-19 (Fever-100 F or greater, chills, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea, vomiting, or diarrhea.**
- ❑ **Tested positive through a diagnostic test for COVID-19.**
- ❑ **Knowingly been in close or proximate contact with anyone who has tested positive through a diagnostic test for COVID-19 or who has had symptoms of COVID-19.**
- ❑ **Traveled internationally or from a restricted state with Widespread community transmission of COVID-19 per the NYS Travel Advisory.**

I attest that the above are true on this date.

Parent Signature: ____

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