Weekly Family COVID-19 Screening Questionnaire

The safety of our children and employees is our paramount priority. As the coronavirus (COVID-19) pandemic continues, we are monitoring the situation closely and following guidelines from the Centers for Disease Control and Prevention and local health authorities. In order to prevent the spread of the coronavirus and reduce the potential risk of exposure to our school, we are asking families to complete and submit this questionnaire each week prior to dropping off their child/children. Please do not sign your child into care until your responses have been reviewed and your entry has been approved.

Please respond to each of the following questions truthfully and to the best of your ability. Your participation is important to help us take precautionary measures to protect you, our children and our employees.

Parent/Guardian Name _____

Child/Children's Name _____

Today's Date _____

Representations
(please circle YES or NO)

1. Over the past 7 days have you or anyone in your household experienced any of the following symptoms? ***(please have your temperature taken by a school manager before you answer this question.)***

Yes	No	Fever (100.4 or greater)
Yes	No	Cough
Yes	No	Shortness of breath or difficulty breathing
Yes	No	Sore throat
Yes	No	New loss of taste or smell
Yes	No	Chills
Yes	No	Head or muscle aches
Yes	No	Nausea, diarrhea vomiting

2. In the past 7 days, have you or anyone in your household been in close proximity to anyone who was experiencing any of the above symptoms or has experienced any of the above symptoms since your contact?
   YES No

3. In the past 7 days, have you or anyone in your household been in close proximity to anyone who has tested positive for COVID-19?
   YES No

4. Have you or anyone in your household been tested for COVID-19 and are you waiting to receive test results?
   Yes No

5. Have you or anyone in your household tested positive for COVID-19, or are you or anyone in your household presumptively positive for COVID-19 based on your health care provider's assessment or your symptoms?
   Yes No

6. In the past 7 days, have you or anyone in your household been on a commercial flight or traveled outside of the United States?
   Yes No

7. In the past 7 days, have you or anyone in your household been in close proximity to anyone who has been on a commercial flight or traveled outside of the United States?
   Yes No

8. Is there any reason why you feel you or anyone in your household are at higher risk of contracting COVID-19 or experiencing complications from COVID-19 by leaving your child in the facility? If "yes", please provide a brief explanation.
   Yes No

   Explanation: _____

Certification

I hereby certify that the responses provided above are true and accurate to the best of my knowledge. I understand that any false information given above will lead to permanent dismissal from Early Care and Education.

Signature: _____ Date: _____

Note: The information collected on this form will be used to determine only whether you may be infected with COVID-19. The information on this form will be maintained as confidential.