Student name:

Week of:

Holy Angels School Covid-19 Screening Tool

If you answered "Yes" to fever and any of the other symptoms listed, do not send your student to school. Please contact your personal healthcare provider for advice.

Monday	Tuesday	Wednesday	Thursday	Friday
Does your student, siblings, or household member or anyone you have been in contact with have any of the following symptoms?	Does your student, siblings, or household member or anyone you have been in contact with have any of the following symptoms?	Does your student, siblings, or household member or anyone you have been in contact with have any of the following symptoms?	Does your student, siblings, or household member or anyone you have been in contact with have any of the following symptoms?	Does your student, siblings, or household member or anyone you have been in contact with have any of the following symptoms?
Fever above 100.4° F? ☐ Yes ☐ No	Fever above 100.4° F? ☐ Yes ☐ No	Fever above 100.4° F? ☐ Yes ☐ No	Fever above 100.4° F? ☐ Yes ☐ No	Fever above 100.4° F? ☐ Yes ☐ No
Chills? ☐ Yes ☐ No	Chills? ☐ Yes ☐ No	Chills? ☐ Yes ☐ No	Chills? ☐ Yes ☐ No	Chills? ☐ Yes ☐ No
Frequent unexplained cough? ☐ Yes ☐ No	Frequent unexplained cough? ☐ Yes ☐ No	Frequent unexplained cough? ☐ Yes ☐ No	Frequent unexplained cough? ☐ Yes ☐ No	Frequent unexplained cough? ☐ Yes ☐ No
Sore throat? ☐ Yes ☐ No	Sore throat? ☐ Yes ☐ No	Sore throat? ☐ Yes ☐ No	Sore throat? ☐ Yes ☐ No	Sore throat? ☐ Yes ☐ No
Shortness of breath and/or trouble breathing? ☐ Yes ☐ No	Shortness of breath and/or trouble breathing? ☐ Yes ☐ No	Shortness of breath and/or trouble breathing? ☐ Yes ☐ No	Shortness of breath and/or trouble breathing? ☐ Yes ☐ No	Shortness of breath and/or trouble breathing? ☐ Yes ☐ No
Persistent pain, pressure, or tightness in the chest? ☐ Yes ☐ No	Persistent pain, pressure, or tightness in the chest? ☐ Yes ☐ No	Persistent pain, pressure, or tightness in the chest? ☐ Yes ☐ No	Persistent pain, pressure, or tightness in the chest? ☐ Yes ☐ No	Persistent pain, pressure, or tightness in the chest? ☐ Yes ☐ No
New loss of taste or smell? ☐ Yes ☐ No	New loss of taste or smell? ☐ Yes ☐ No	New loss of taste or smell? ☐ Yes ☐ No	New loss of taste or smell? ☐ Yes ☐ No	New loss of taste or smell? ☐ Yes ☐ No
Have the student or others in your household traveled outside of our local area within the past 14 days? ☐ Yes ☐ No	Have the student or others in your household traveled outside of our local area within the past 14 days? ☐ Yes ☐ No	Have the student or others in your household traveled outside of our local area within the past 14 days? ☐ Yes ☐ No	Have the student or others in your household traveled outside of our local area within the past 14 days? ☐ Yes ☐ No	Have the student or others in your household traveled outside of our local area within the past 14 days? ☐ Yes ☐ No
Has your student, siblings, or household member been in contact with tested positive for Covid-19? ☐ Yes ☐ No	Has your student, siblings, or household member been in contact with tested positive for Covid-19? ☐ Yes ☐ No	Has your student, siblings, or household member been in contact with tested positive for Covid-19? ☐ Yes ☐ No	Has your student, siblings, or household member been in contact with tested positive for Covid-19? ☐ Yes ☐ No	Has your student, siblings, or household member been in contact with tested positive for Covid-19? ☐ Yes ☐ No
If yes, please provide approximate dates of illness:	If yes, please provide approximate dates of illness:	If yes, please provide approximate dates of illness:	If yes, please provide approximate dates of illness:	If yes, please provide approximate dates of illness:
From: _____	From: _____	From: _____	From: _____	From: _____
Through: _____	Through: _____	Through: _____	Through: _____	Through: _____
Parent notes:	Parent notes:	Parent notes:	Parent notes:	Parent notes:
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____ Parent Initials	_____ Parent Initials	_____ Parent Initials	_____ Parent Initials	_____ Parent Initials