

Student Name: \_\_\_\_\_

Grade Level/Teacher: \_\_\_\_\_

### **Vale Elementary Student Daily Symptom Check**

This is your child’s daily symptom check required to attend school. Based on your responses, you will either be approved to come to school, or you will be directed to follow other procedures. By completing the survey and submitting your responses, you agree that the information collected can be used by the school to provide a safe environment for all. The data will be used solely to determine if your child should attend / come to school at this time and will be kept confidential.

| <b>Symptom Check Questions: (Circle Yes or No)</b>   | <b>Monday</b> | <b>Tuesday</b> | <b>Wednesday</b> | <b>Thursday</b> | <b>Friday</b> |
|--|---------------|----------------|------------------|-----------------|---------------|
| <b>1. <u>Do you have any of the following symptoms that <i>are not caused by another condition?</i></u></b> <ul style="list-style-type: none"><li>- Shortness of breath or difficulty breathing</li><li>- Fever (100.4 F or higher) or chills</li><li>- Cough</li><li>- Recent loss of taste or smell</li><li>- Congestion or runny nose</li><li>- Sore throat</li><li>- Muscle or body aches</li><li>- Headache</li><li>- Unusual fatigue</li><li>- Nausea or vomiting</li><li>- Diarrhea</li></ul> | <b>Yes</b>    | <b>Yes</b>     | <b>Yes</b>       | <b>Yes</b>      | <b>Yes</b>    |
|  | or            | or             | or               | or              | or            |
|  | <b>No</b>     | <b>No</b>      | <b>No</b>        | <b>No</b>       | <b>No</b>     |
| <b>2. <u>Do any of the following statements apply to you?</u></b> <ul style="list-style-type: none"><li>- Been in close contact with someone who has tested positive for COVID-19</li><li>- Told by a public health or medical professional to self-monitor, self-isolate, or self-quarantine because of concerns about COVID-19 infection</li><li>- Had a positive COVID-19 test for active virus in the past 10 days</li></ul>   | <b>Yes</b>    | <b>Yes</b>     | <b>Yes</b>       | <b>Yes</b>      | <b>Yes</b>    |
|  | or            | or             | or               | or              | or            |
|  | <b>No</b>     | <b>No</b>      | <b>No</b>        | <b>No</b>       | <b>No</b>     |

\*If you answered “Yes” to any of the questions on any given day, please do not send your child to school and contact your physician for guidance.

\*If symptoms your child is experiencing can be directly connected to another or preexisting condition, please answer “No.”