Health Survey

Date: _________

Name: (child/family)__________________________________

Today or in the past 24 hours, have you or any household members had any of the following symptoms?

Fever (temperature of 100.0 F), felt feverish, or chills **Y N**

Cough **Y N**

Sore throat **Y N**

Difficulty breathing **Y N**

Gastrointestinal symptoms (diarrhea, nausea, vomiting) **Y N**

Fatigue **Y N**

Headache **Y N**

New loss of smell/taste **Y N**

New muscle aches **Y N**

Any other signs of illness **Y N**

In the past 14 days, have you had close contact with a person known to be infected with the novel coronavirus (COVID-19)? **Y N**

Signed in by: ______________________________