Creative Learning Pod – Fall 2020

Daily Health Questionnaire

Please complete a separate Daily Health Questionnaire for each student in your care who is participating in the Creative Learning Pod.

Student	
FIRST NAME	LAST NAME

Has your child <u>or anyone in your household</u> experienced any of the following symptoms of COVID-19 since the last time they attended the Creative Learning Pod, or within the last 72 hours? [check all that apply]	
☐ FEVER OF 100.4° F OR ABOVE	☐ MUSCLE ACHES/PAINS
☐ COUGH	☐ SHORTNESS OF BREATH / DIFFICULTY BREATHING
☐ SORE THROAT	☐ DIARRHEA
☐ CHILLS/REPEATED SHAKING WITH CHILLS	☐ NAUSSEA/VOMITING
☐ HEADACHE	☐ RUNNY NOSE / CONGESTION
☐ LOSS OF TASTE OR SMELL	☐ UNUSUAL FATIGUE

Has your child or anyone in your household been in known contact with anyone who has a suspected or confirmed case of COVID-19?	YES ☐ NO ☐
Has your child taken any medication to reduce fever in the last 24 hours?	YES ☐ NO ☐

Notes
IS THERE ANYTHING ELSE THAT WE SHOULD KNOW ABOUT YOUR STUDENT'S HEALTH TODAY?

Parent/Guardian Signature		
PRINT NAME	SIGNATURE	DATE