Raleigh County Return to School

COVID-19 Screening Form

Name: _____ Date: _____

School: _____ Grade: _____

Best phone number to contact: _____

Yes No Have you travelled outside of West Virginia within the last 14 days?

Locations: _____

Yes No Temperature > 100.4 Recorded Temperature _____

Yes No Have you had contact " with a person with a confirmed case of COVID-19?

Yes No Have you had contact* with a person with a suspected case of COVID-19?

Contact is defined as less than 6 feet separation for more than 15 minutes without adequate personal protective equipment.

Yes No Have you had a fever within the last 14 days?

Yes No Have you had a forceful dry cough or productive cough within the last 14 days?

Yes No Have you had difficulty breathing or shortness of breath within the last 14 days?

Yes No Have you had chills or repeated shaking with chill within the last 14 days?

Yes No Have you had new unexplained muscle pain within the last 14 days?

Yes No Have you had new or atypical headache for you within the last 14 days?

Yes No Have you had nausea, vomiting or diarrhea within the last 14 days?

Yes No Have you had a sore throat within the last 14 days?

Yes No Have you been tested for COVID-19 in the last 2 weeks?

Yes No Have you had a recent sudden loss of taste or smell?

Signature: _____ Date: _____