WBCS Daily COVID19 Screening Form (student, employee, visitor)

First Name ______________________ Last Name______________________ Grade__________

Temperature (**recorded by staff on arrival**): ______________________

Within the last 14 days, have you experienced any of the following symptoms?

- ○ Fever (100° or higher)
- ○ New and persistent cough
- ○ Shortness of breath or difficulty breathing
- ○ New and non-typical fatigue
- ○ New loss of taste of smell

If any of the 5 **above** are checked – **go home immediately** and **self-isolate** until you have **no symptoms for 3 full days** without the use of any medication, **and** it has been **10 days since the first day of symptoms** (whichever duration is longer)

- ○ Test Positive for COVID-19? (or any member of my household)
- ○ Been in close contact with anyone experiencing symptoms of or tested positive for COVID-19? (spent long than 15 min withing 6 ft)
- ○ Traveled internationally or visited an area of the US considered to be highly affected by COVID-19? (self or household member)

If any of the 3 above are checked, **self-quarantine** for 10 days from the date of the positive test or 14 days from the exposure, or until a doctor validates that it is safe to return.

Parent validation signature: ______________________________Date: _____________

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