Student Symptom Checker

Student's Name:_____ Site Location:_____ Month:_____

Instructions: Students must undergo a symptom check prior to coming to school. Please check your symptoms' at home, select Y=Yes or N=No and record. If you answer **YES** to any of the below questions, you must stay home. For weekends, draw a line through the date. If you have questions, please contact your school nurse or administration.

Date	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Initials																															
Exposure to COVID-19 in the past 10 days?	Y N																														
Are you feeling ill?	Y N																														
Record temperature if ≥100.4 stay home																															
• Cough • Short of breath • Difficulty breathing • Chills • Fatigue • Muscle ache • Congestion/runny nose • Sore throat • Headache • New loss of taste Or smell • Nausea • Vomiting • Diarrhea	Y N																														

Employee Symptom Checker

Excellence by Design

Employee Name:_____ Site Location:_____ Month:_____

Instructions: Employees must undergo a symptom check prior to entering the workspace. Please check your symptoms' at home, select Y=Yes or N=No and record. If you answer yes to any of the below questions, you must stay home. For weekends, draw a line through the date. If you have questions, please contact human resources.

Date	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Initials																															
Exposure to COVID-19 in the past 10 days?	Y N																														
Are you feeling ill?	Y N																														
Record temperature if ≥100.4 stay home																															
• Cough • Short of breath • Difficulty breathing • Chills • Fatigue • Muscle ache • Congestion/runny nose • Sore throat • Headache • New loss of taste Or smell • Nausea • Vomiting • Diarrhea	Y N																														