



# Daily Screening Questionnaire for COVID-19

**Families / Students / Staff, please use this risk assessment each day to decide if you should enter a school or NESD facility.**

Do you, or your child attending school, have any of the following symptoms:	Check one	
• Fever	<input type="radio"/> YES	<input type="radio"/> NO
• Cough	<input type="radio"/> YES	<input type="radio"/> NO
• Headache	<input type="radio"/> YES	<input type="radio"/> NO
• Muscle and/or joint aches and pains	<input type="radio"/> YES	<input type="radio"/> NO
• Sore throat	<input type="radio"/> YES	<input type="radio"/> NO
• Chills	<input type="radio"/> YES	<input type="radio"/> NO
• Runny nose	<input type="radio"/> YES	<input type="radio"/> NO
• Nasal congestion	<input type="radio"/> YES	<input type="radio"/> NO
• Conjunctivitis	<input type="radio"/> YES	<input type="radio"/> NO
• Dizziness	<input type="radio"/> YES	<input type="radio"/> NO
• Fatigue	<input type="radio"/> YES	<input type="radio"/> NO
• Nausea/vomiting	<input type="radio"/> YES	<input type="radio"/> NO
• Diarrhea	<input type="radio"/> YES	<input type="radio"/> NO
• Loss of appetite (difficulty feeding for children)	<input type="radio"/> YES	<input type="radio"/> NO
• Loss of sense of taste or smell	<input type="radio"/> YES	<input type="radio"/> NO
• Shortness of breath	<input type="radio"/> YES	<input type="radio"/> NO
• Difficulty breathing	<input type="radio"/> YES	<input type="radio"/> NO

If you have answered “**Yes**” to any of the above questions, please **DO NOT** enter the school/NESD facility at this time.

If you have answered “**No**” to all the questions above, you may attend school/NESD facility.