Preschool Sign-in/Child Health Screening/Symptom Check

Student Name_______________ Grade _____

Parents/Guardians, Please fill out this questionnaire to decide if your child should enter today. Circle Yes or No for each symptom.

DATE	Fever Temp.	Cough	Shortness Of Breath	Runny Nose Or Congestion	Head Or Body Aches or chills	Nausea, Vomiting, Or Diarrhea	Loss Of Taste Or Smell or Sore Throat	Contact With Sick Person	Time in	**Parent Signature**
	Yes **No** _____°	**Yes** **No**	**Yes** **No**	**Yes** **No**	**Yes** **No**	**Yes** **No**	**Yes** **No**	**Yes** **No**		

If you answered yes to any of the above questions, please DO NOT leave your child. If you answered no to all, you may sign in.

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	Yes **No** _____°	**Yes** **No**	**Yes** **No**	**Yes** **No**	**Yes** **No**	**Yes** **No**	**Yes** **No**	**Yes** **No**		

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