COVID-19 Symptom Screening Tool: Pre K-12 and Child Care

Name: _____ **Date:** _____ **Temperature:** _____

*This form can be filled out at home by a staff member, teacher, parent/guardian, or teen.

HAVE YOU HAD ANY OF THE FOLLOWING SYMPTOMS IN THE PAST THREE DAYS?	YES	NO
MAJOR SYMPTOMS		
COUGH		
SHORTNESS OF BREATH OR DIFFICULTY BREATHING		
RECENT LOSS OF TASTE OR SMELL		
MINOR SYMPTOMS		
FEVER OR CHILLS		
MUSCLE OR BODY ACHES		
SORE THROAT		
FATIGUE		
RUNNY NOSE OR STUFFY NOSE		
HEADACHE		
NAUSEA OR VOMITING		
DIARRHEA		

DO NOT ENTER THE SCHOOL/BUILDING IF:

You have any ONE of the MAJOR symptoms or any TWO of the MINOR symptoms listed above and you haven't been provided a different diagnosis by a healthcare provider, whether or not you're vaccinated.

- If you have symptoms of COVID-19, stay home, isolate from the people you live with, get tested for COVID-19, and call your healthcare provider.

- Learn more about quarantine and isolation at covid.ri.gov/whattodo
- Learn more about testing at covid.ri.gov/testing

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