Fall for Indian Rock Daily Health Questionnaire

Childs Name_____ Date_____

Has your child been in close contact with a person who has been diagnosed with, tested for, or quarantined as a result of COVID-19 in the last 14 days? **Y N**

Has your child taken any fever reducing medicine prior to coming here today? If yes, why was it taken? **Y N**

Does your child have a history of pollen allergies that will induce coughing or sneezing? **Y N**

Does your child have any of the following symptoms?

Shortness of breath or difficulty breathing	**Y N**	Sore throat	**Y N**
Fever	**Y N**	New loss of taste or smell	**Y N**
Chills	**Y N**	Generalized abdominal pain	**Y N**
New cough/congestion	**Y N**	Gastrointestinal symptoms including nausea, vomiting, or diarrhea	**Y N**

Parent/Guardian Signature_____

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