Manasquan Elementary School
Summer Skills Program Daily Screening Questionnaire

Please have student report to school with this form filled out <u>EVERY</u> day. No student will be admitted to the building without a completed Daily Pre-Screening form.

Name of Student: _____ Date: _____

Parent/Guardian Cell: _____

Are you experiencing any of the following symptoms?

	Please Circle One	
1. Fever (≥ 100.4°F)	**YES**	**NO**
2. Cough or shortness of breath	**YES**	**NO**
3. Sore Throat	**YES**	**NO**
4. Chills	**YES**	**NO**
5. Muscle aches or rigors	**YES**	**NO**
6. Headache	**YES**	**NO**
7. New loss of taste or smell	**YES**	**NO**
8. Abdominal pain, nausea, vomiting or diarrhea	**YES**	**NO**
Have you had close contact with someone who is currently sick?	**YES**	**NO**
Have you been diagnosed with COVID-19 in the past three weeks or have reason to believe you have COVID-19?	**YES**	**NO**
Have you traveled or had close contact with anyone who has traveled internationally in the last 14 days?	**YES**	**NO**

If you took your temperature this morning, what was the reading? _____

School Use Only

Recorded Temperature: _____

Initial: _____