WOODLAND PARK SCHOOLS
Special Services Department
853 McBride Avenue
Woodland Park, NJ 07424
HEALTH SCREENING FORM

Parents/Guardians:

Please complete this short health check each morning. Your initials under the date in the calendar below indicate your child is **free of symptoms** (section 1) and has not had close contact/potential exposure to Covid (section 2). THIS MUST BE COMPLETED DAILY FOR ADMISSION INTO THE BUILDING.

Section 1: Symptoms

Any of the symptoms below could indicate a COVID-19 infection in children and may put your child at risk for spreading illness to others. Please check your child daily for these symptoms:

• Fever (greater than 99.9) • Chills • Rigors (shivers) • Myalgia (muscle aches) • Headache • Sore Throat • Nausea or Vomiting	• Diarrhea • Fatigue • Congestion or runny nose • Cough • Shortness of Breath • Difficulty Breathing • New loss of smell or taste

Section 2: Close Contact/Potential Exposure

Please verify if:

- Your child has had close contact (within 6 feet of an infected person for at least 10 minutes) with a person with confirmed COVID-19
- Someone in your household is diagnosed with COVID-19
- Your child has traveled to an area of high community transmission.

If ANY of the statements in Section 2 are TRUE, your child should remain home.

Contact the school nurse, your child's provider, or your local health department for further guidance.

I UNDERSTAND THAT BY INITIALING THIS CALENDAR EACH DAY MY CHILD ATTENDS SCHOOL, I AM ATTESTING TO THE FACT THAT MY CHILD HAS NOT EXPERIENCED ANY OF THE SYMPTOMS IN SECTION 1 ABOVE IN THE LAST 24 HOURS AND HAS NOT HAD CLOSE CONTACT OR POTENTIAL EXPOSURE TO THE VIRUS AS STATED IN SECTION 2.

PARENT SIGNATURE:_____   DATE:_____

PRINT PARENT'S NAME:

Child's name _____   Grade:_____

Teacher: _____

September 2020

Monday	Tuesday	Wednesday	Thursday	Friday
	8	9	10	11
14	15	16	17	18
21	22	23	24	25
28	28	30		

October 2020

Monday	Tuesday	Wednesday	Thursday	Friday
			1	2
5	6	7	8	9
	13	14	15	16
19	20	21	22	23
26	27	28	29	30