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

HEALTH SCREENING FORM

Student Name _____ **Date** _____

Parents/Guardians: Please complete this short check each morning and report your child's information per your school's reporting instructions.

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 note that this list does not include all possible symptoms and children with COVID-19 may experience any, all, or none of these symptoms. Please check your child daily for these symptoms:

Column A	**Column B**
☐ Chills ☐ Rigors (shivers) ☐ Myalgia (muscle aches) ☐ Headache ☐ Sore Throat ☐ Nausea or Vomiting ☐ Fatigue ☐ Congestion or runny nose	☐ Fever ☐ Cough ☐ Shortness of Breath ☐ Difficulty Breathing ☐ Diarrhea ☐ New loss of smell ☐ New loss of taste

Students who are sick (e.g. fever, vomiting, diarrhea) should not attend school in-person. If **TWO OR MORE of the fields in Column A** are checked off **OR AT LEAST ONE field in column B** is checked off, please keep your child home and notify the school for further instructions.

Section 2: Close Contact/Potential Exposure

Please verify if in the last 14days:

☐ Your child has had close contact (within 6 feet of an infected person for 15 or more minutes during a 24-hour period) with a person with COVID-19
☐ Someone in your household is diagnosed with or being tested for COVID-19
☐ Your child has traveled from any U.S. state or territory outside of New York, Connecticut, Pennsylvania, and Delaware and is not otherwise exempt from quarantine under the DOH travel restrictions.

If ANY of the fields in Section 2 are checked off, contact your school for exclusion recommendations. Contact your child's healthcare provider or your local health department for further guidance.

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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:_____

Child's name _____

Grade:_____

February 2021

22	**23**	**24**	**25**	**26**

March 2021

1	**2**	**3**	**4**	**5**
8	**9**	**10**	**11**	**12**
15	**16**	**17**	**18**	**19**
22	**23**	**24**	**25**	**26**