

***St. John Extended Daycare Screening Form***

 Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Grade\_\_\_\_\_\_\_\_\_\_\_\_\_

  **Temperature:**

|  |  |  |
| --- | --- | --- |
| Arrival: | Mid-day: | Pick up: |
|  |  |  |

**Has the child had any of the following symptoms of COVID-19 since the last time they were in care?**

* A cough
* Shortness of breath or difficulty breathing
* A fever of 100.4°F or higher, or a sense of having a fever
* A sore throat
* Chills
* New loss of taste or smell
* Muscle or body aches
* Nausea/vomiting/diarrhea
* Congestion/running nose – not related to seasonal allergies
* Unusual fatigue

**Does anyone in your household have any of the above symptoms that are not attributable to another condition?**

* + **Yes**
	+ **No**

**Has your child been close with anyone suspected or confirmed with COVID-19?**

* + **Yes**
	+ **No**

**Has your child/youth had any medication to reduce a fever before coming to school?**

* + **Yes**
	+ **No**

**Has your had Sunscreen applied before arrival**

* + **Yes**
	+ **No**

Screened by: /RO\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/KC\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/JB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



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Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Staff**

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