Dear parents and guardians;

Please complete this assessment at home every day prior to your son/daughter going to school in the morning.

Does your son/daughter have any of these symptoms?

- Cough
- Congestion or runny nose
- Chills/Fever
- Headache
- Muscle pain (with no reason)
- Sore throat
- Loss of taste or smell
- Digestive problems
Is your son/daughter’s temperature above 99.9 degrees Fahrenheit?
Yes ________________ No ________________

Have they traveled to any of the restricted states published by the PA DOH in the last 14 days?
Yes ________________ No ________________

Have they or anyone in your household been instructed to quarantine or been in close contact with a person who was diagnosed with COVID-19 or been instructed to quarantine with symptoms of COVID-19 in the past 14 days?
Yes ________________ No ________________

If you answered yes to any of these questions, please stay home and contact your school nurse and your son/daughter’s doctor.