New Brighton Area School District

CORONAVIRUS (COVID-19) SCREENING TOOL

1. Have you had close contact with someone who is positive for COVID19? Y/N
2. Are you or anyone in your household awaiting the results of a COVID19 test? Y/N
3. Have you taken any fever reducing medication in the past 24 hours? Y/N
4. Have you had any **ONE** of the following in the last 24 hours?: Y/N
    a. Cough
    b. Shortness of breath
    c. Difficulty breathing
    d. Change in taste or smell
5. Have you had any **TWO** of the following in the last 24 hours? Y/N
    a. Fever
    b. Chills
    c. Rigors
    d. Myalgia
    e. Headache
    f. Sore throat
    g. Nausea or vomiting
    h. Diarrhea
    i. Fatigue
    j. Congestion or runny nose

If you or your child has answered yes to any of the above, please stay home or keep your child home and contact your supervisor or the school nurse.