



PARTICIPANT WELLNESS SCREENING CHECKLIST DURING COVID-19

The District is requiring every participant to conduct their own wellness screening every day prior to reporting to district programs. If Participant responds "yes" to any of the following questions, they are to notify the district and remain home.

Upon notification, the district will follow the established protocol according to the Restoration of Operations Procedures Manual for proper handling.

QUESTION	NO	YES
1. Have you felt feverish or do you have a fever 100.4° or above?		
2. Do you have a new or unusual cough?		
3. Do you have a new or unusual sore throat?		
4. Have you been experiencing new or unusual difficulty breathing or a shortness of breath?		
5. Do you have unexplained muscle aches?		
6. Have you had a new or unusual headache (not related to caffeine, diet or hunger, not related to a history of migraines, clusters, or tension, not typical to the individual)?		
7. Have you noticed a new loss of taste or loss of smell?		
8. Have you been experiencing unexplained or unusual chills, shivering or sweating?		
9. Do you have any gastrointestinal concerns such as abdominal pain, vomiting or diarrhea?		
10. Is anyone in your household displaying any new or unusual symptoms related to COVID-19?		
11. To the best of your knowledge, have you or anyone in your household come into close contact with anyone who has tested positive for COVID-19?		