Initial of parent completing the checklist	What was your child's temperature when checked this morning?	Has anybody in your household been asked to self quarantine due to exposure to someone diagnosed with COVID-19?	Has your child had close contact with someone diagnosed with COVID-19?	Has your child traveled internationally or to a state on the CT travel advisory list in the past 14 days?	Hives or rash YES	Congestion or runny nose YES	New fatigue YES	Nausea or vomiting YES	Headache	Diarrhea	New loss of taste or smell YES	Sore throat YES	Muscle or body aches YES	Shortness of breath or difficulty breathing YES	Chills YES	Cough		Is your child experiencing any symptons of COVID-	Parent Phone Number: 10	Student Name:
		NO	NO	NO	NO	NO	NO	NO	NO	NO	OM	NO	NO	NO	NO	NO	below	Circle	10/16	
		YES	YES	YES	YES	SEX	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	below	Circle	10,	
		ON	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	low	cle	10/19	
		YES	YES	YES	YES	YES	SHY	YES	YES	YES	YES	YES	YES	YES	YES	YES	below	Circle	10/20	
		ON	ŏ	ON	NO	NO	NO	NO	NO	NO	ON	ON	NO	NO	NO	NO	OW	e de	20	
		YES	YES	YES	YES	SEA	YES	YES	YES	SEY	YES	SEY	SHA	YES	YES	YES	below	Circle	10/21	COVID 19 Symptom
		NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	W	e e	21	D 19
		YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	below	Circle	10/22	Sym
		NO	ON	NO	NO	ON	NO	NO	ON	NO	NO	NO	ON	NO	NO	NO	₹ 0	le	22	ptom
		YES	YES	YES	YES	SEX	YES	SEY	YES	YES	YES	YES	YES	YES	YES	YES	below	Circle	10/23	
		NO	NO	NO NO	ON	NO	ON	NO	ON	NO	NO	NO	ON	NO	NO	ON	¥ £	e e	23	cklis
		YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	SIX	YES	below	Circle	10/26	Checklist - Student
		NO	Ö	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	¥	₽	26	uden
		YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	below	Circle	10/27	7
<u></u>		NO	ON	NO	NO	NO	No	NO	NO	NO	NO	NO	NO	NO	NO	NO	* .	1 6	27	
		YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	below	Circle	10/28	
		ON	NO	ON	ON	NO	NO	NO	ON	NO	OM	ON	NO	NO	NO	NO	JW.	ë	28	
		YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	SHY	YES	YES	SHA	below	Circle	10/29	
		NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	OW	cle	29	
		YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	below	Circle	10/30	
		NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	JW C	ř	30	

This checklist must be completed by a parent or guardian each day before arriving at St. Rose of Lima School. Students should stay home if answering YES to any of the questions above.

Students should stay home if the measured temperature greater than 100 degrees F.

If this checklist is not complete, or not presented to the teacher upon arrival, or presented indicating YES to any answer, the student will be screened by the school nurse and parents will be called to bring the child home.

Please be sure to have a plan in place for timely pick up should your child need to go home.

Re-entry following illness: a note from a healthcare provider clearing your child will be required.

Student Name:							COVI	ID 19) Syn	aptor	D 19 Symptom Checklist - Student	eckli	st-S	tude	p#					
Parent Phone Number:	10/1	/1	10/2	/2	10/5	/5	10/	/6	Ä	10/7	ă	10/8	10	10/9	Oï	10/13	10/14	4	10/15	5
Is your child experiencing any symptons of COVID-	Circle	ile	Circle	de	Circle	cle	Cir	Circle	Ci.	Circle	ਲ	Circle	Circle	cle	5:	Circle	Circle	le	Circle	ଚ
19 listed below?	answer below	ow rer	answer below	ow	answer below	ow	answer below	inswer below	answer	unswer below	answer	nswer helow	answer helow	nswer helow	ans	answer helow	answer	ver ow	answer	€ Çî
Cough	YES	NO	YES	NO	YES	No	XEX	NO	YES	No	YES	NO	SEX	NO	YES	NO	YES	NO	SHA	ő
Chills	YES	NO	YES	NO	YES	NO	XES	ON	YES	No	YES	ON	YES	NO	YES	NO	YES	NO	YES	NO
Shortness of breath or difficulty breathing	SIX	NO	YES	No	YES	NO	YES	ON	YES	No	YES	NO	SIX	NO	YES	NO	YES	ON	YES	No
Muscle or body aches	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	SEX	NO	YES	NO	YES	Ñ	YES	NO	SHY	NO
Sore throat	YES	NO	YES	OM	YES	ON	SHY	NO	YES	ON	YES	NO	SHY	ON	YES	NO	YES	NO	YES	NO
New loss of taste or smell	YES	NO	XES	NO	YES	NO	YES	NO	XES	ON	YES	NO	SXX	NO	SHY	NO	YES	NO	YES	NO
Diarrhea	YES	NO	YES	ON	YES	NO	YES	NO	SHX	NO	YES	NO	YES	ON	SHY	ON	YES	NO	YES	NO
Headache	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	OM	YES	NO	YES	NO
Nausea or vomiting	YES	NO	YES	NO	YES	NO	YES	ON	YES	NO	YES	NO	YES	NO	YES	ON	YES	NO	YES	NO
New fatigue	YES	No	YES	NO	YES	NO	XES	NO	YES	ON	YES	NO	SEX	NO	YES	NO	SEX	NO	YES	NO
Congestion or runny nose	YES	Ñ	YES	ON	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
Hives or rash	YES	NO	YES	OM	YES	ON	YES	NO	YES	NO	YES	No	YES	NO	YES	NO	YES	ON	SHY	ON
Has your child traveled internationally or to a state on the CT travel advisory list in the past 14 days?	YES	NO	YES	NO	YES	NO	YES	ON	XES	NO	YES	NO	YES	ON	YES	NO	YES	ON	SIX	NO
Has your child had close contact with someone diagnosed with COVID-19?	YES	NO	YES	ON	YES	NO	YES	NO	YES	ON	SEX	ON	STA	ON	YES	ON	SEX	ON	YES	NO
Has anybody in your household been asked to self quarantine due to exposure to someone diagnosed with COVID-19?	YES	NO	YES	NO	YES	NO	YES	NO	SEX	NO N	YES	No	YES	NO	YES	ON	YES	N O	YES	NO
What was your child's temperature when checked this morning?																				
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