



**MONROE TOWNSHIP SCHOOLS**  
**423 Buckelew Avenue**  
**Monroe Township, New Jersey 08831**  
**www.monroe.k12.nj.us**

**DORI L. ALVICH, Ed.D.**

Superintendent of Schools

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Assistant Superintendent of Schools

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Business Administrator/Board Secretary

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**Daily COVID-19 PRE-SCREENING QUESTIONNAIRE for Students**

<b>Student Name</b>	<b>Grade (2020-2021)</b>	
<b>School Attended</b>	<b>Applegarth</b> <input type="checkbox"/> <b>Barclay Brook</b> <input type="checkbox"/> <b>Brookside</b> <input type="checkbox"/> <b>Mill Lake</b> <input type="checkbox"/>	<b>Oak Tree</b> <input type="checkbox"/> <b>Woodland</b> <input type="checkbox"/> <b>Middle School</b> <input type="checkbox"/> <b>High School</b> <input type="checkbox"/>
<b>Please check yes or no for each question below ("You" refers to the student in all questions):</b>	<b>YES</b> <input type="checkbox"/>	<b>NO</b> <input type="checkbox"/>
<b>Is your temperature greater than 100.0° Fahrenheit?</b>	<b>YES</b> <input type="checkbox"/>	<b>NO</b> <input type="checkbox"/>
<b>Are you experiencing a cough or shortness of breath?</b>	<b>YES</b> <input type="checkbox"/>	<b>NO</b> <input type="checkbox"/>
<b>Are you experiencing a sore throat?</b>	<b>YES</b> <input type="checkbox"/>	<b>NO</b> <input type="checkbox"/>
<b>Are you experiencing chills?</b>	<b>YES</b> <input type="checkbox"/>	<b>NO</b> <input type="checkbox"/>
<b>Are you experiencing a headache?</b>	<b>YES</b> <input type="checkbox"/>	<b>NO</b> <input type="checkbox"/>
<b>Are you experiencing a new loss of taste or smell?</b>	<b>YES</b> <input type="checkbox"/>	<b>NO</b> <input type="checkbox"/>
<b>Are you experiencing abdominal pain, nausea, vomiting, or diarrhea?</b>	<b>YES</b> <input type="checkbox"/>	<b>NO</b> <input type="checkbox"/>
<b>Have you been in close contact with someone who is known to have COVID-19?</b>	<b>YES</b> <input type="checkbox"/>	<b>NO</b> <input type="checkbox"/>
<b>Have you been diagnosed with COVID-19 in the past 2 weeks?</b>	<b>YES</b> <input type="checkbox"/>	<b>NO</b> <input type="checkbox"/>
<b>Do you have reason to believe that you have COVID-19?</b>	<b>YES</b> <input type="checkbox"/>	<b>NO</b> <input type="checkbox"/>
<b>Have you traveled internationally in the past 14 days?</b>	<b>YES</b> <input type="checkbox"/>	<b>NO</b> <input type="checkbox"/>
<b>Have you traveled overnight to any of THE STATES LISTED ON THE NJ.GOV (<a href="http://nj.GOV">http://nj.GOV</a>) WEBSITE REQUIRED TO SELF-QUARANTINE in the past 14 days?</b>	<b>YES</b> <input type="checkbox"/>	<b>NO</b> <input type="checkbox"/>

**If you answered YES for any of the questions, please do not bring your child to school and contact the school nurse.**

Parent Name (print)

Parent Signature

Parent Contact #

Date