Name: ________________________________ **Date**:_____________

1: Have you or your child traveled outside of NH, VT, ME, RI, CT recently?
___ Yes ___No

If Yes, please explain:____

2: Are you / your child experiencing **any symptoms** consistent with COVID-19?
(For Example: cough, temperature, shortness of breath, difficulty breathing, chills, muscle pain, headache, sore throat or new loss of taste or smell?).
___ Yes ___No

If Yes, please explain:____

3. Have you / your child been **in close contact** recently with anyone known to have or suspected of having COVID-19? ___ Yes ___No

If Yes, please explain:____

By signing the here, I confirm that my child and I have no symptoms and no known exposure to COVID-19.

To be completed by MFCS Staff Only:

4. **Temperature** Recorded: _____________ Staff Initials: ___________

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