Symptom Screening Tool

Name: _____ Building: _____

This form is to be utilized as a voluntary self-check to monitor for symptoms of illness. Fill out daily, or prior to student reporting to school. Keep this form for your records.

If you have the following symptoms such as: Fever or chills, cough, shortness of breath, fatigue, muscle or body aches, headache, new loss of taste or small, sore throat, congestion or runny nose, nausea/vomiting, or diarrhea, please check with a medical professional before entering the school building.

Check testiowa.com for more information and potential testing recommendations.

Known exposure to someone with a confirmed COVID-19 test over past 14 days. Date: _____

Date / Time	Check here, if on this day, you are in self-isolation or quarantine	Any symptoms noted? (Yes / No)	Temperature in degrees Fahrenheit	What are your symptoms? (If no symptoms are experienced on this day, write 'None')

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