KEANSBURG SCHOOL DISTRICT

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Mr. John D. Covert	**Ms. Kathleen O'Hare**	**Ms. Louise B. Davis**
Superintendent of Schools	*District Director of Operations, C & I, State & Federal Programs*	*Interim Business Administrator/ Board Secretary*

COVID-19 DAILY SCREENING FOR STUDENTS/STAFF

Name: _____   **Date:** _____

Parents/Guardians: Please complete this short check each morning and report your child's information per your school's reporting instructions.

Section 1: Symptoms

Any of the symptoms below could indicate a COVID-19 infection to children and may put your child at risk for spreading illness to others. Please note that this list does not include all possible symptoms and children with COVID-19 may experience any, all, or none of these symptoms. Please check your child daily for these symptoms.

Column A-Check All That Apply		Column B-Check All that Apply	
	Fever (measured or subjective)		Cough
	Chills		Shortness of Breath
	Rigors		Difficulty Breathing
	Myalgia (muscle aches)		New Loss of Smell
	Headache		New Loss of Taste
	Sore Throat		
	Nausea or Vomiting		
	Diarrhea		
	Fatigue		
	Congestion or Runny Nose		

If **TWO OR MORE of the fields in Column A** are checked or **OR AT LEAST ONE field in Column B** is checked off, please keep your child home and notify the school for further instructions.

Section 2: Close Contact/Potential Exposure

Please verify if:

	Your child has had close contact (within 6 feet of an infected person for at least 10minutes) with a person with confirmed COVID-19
	Someone in your household is diagnosed with COVID-19
	Your child has traveled to an area of high community transmission.

If ANY of the fields in Section 2 are checked off, your child should remain home for 14 days from the last date of exposure (if the child is a close contact of a confirmed COVID-19 case) or date of return to New Jersey.

Contact your child's provider or your local health department for further guidance.