

**Wilson School District  
Participant and Staff COVID-19 Screening**

**1.) In the last 14 days have you had any of the following symptoms: Fever or chills (100.4 or higher), cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea?** YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, please describe:

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If yes, did you seek medical treatment? YES \_\_\_\_\_ NO \_\_\_\_\_

**2.) In the last 14 days have you had close contact with someone who is currently sick with suspected or confirmed COVID-19? (Note: Close contact is defined as within 6 feet for more than 10 consecutive minutes, without PPE equipment.)** YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, please describe:

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If yes, did you seek medical treatment? YES \_\_\_\_\_ NO \_\_\_\_\_

**Participant/Staff Member Printed Name:** \_\_\_\_\_

**Participant/Staff Member Phone Number:** \_\_\_\_\_

**Date:** \_\_\_\_\_

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