Wilson School District

Participant and Staff COVID-19 Screening Form

1.) In the last 14 days have you had any of the following symptoms: Fever or chills (100.0 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:

_____

_____

_____

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:

_____

_____

_____

If yes, did you seek medical treatment? YES _____ NO _____

Participant/Staff Member Printed Name:

_____

Participant/Staff Member Phone Number:

_____

Date:

_____