Symptom Screen Form

Champaign 4 UNIT SCHOOL DISTRICT

Name: _____ Date: _____

District Building: _____

In the past two days (48 hours), have you experienced:

YES	NO	
☐	☐	Fever (100.4 F or higher), new onset of moderate or severe headache
☐	☐	Shortness of breath, new cough, sore throat, fatigue from unknown cause
☐	☐	Nausea, vomiting, diarrhea, abdominal pain from unknown cause
☐	☐	New congestion/runny nose, new loss of sense of taste or smell, muscle or body aches
☐	☐	Close contact (closer than six feet for at least 15 minutes) with anyone with suspected or confirmed Covid-19? Been instructed to isolate or self-quarantine?
☐	☐	Have you taken any medication to reduce a fever in the past 24 hours?

Temperature: _____ Parent/Guardian/Staff/Visitor Signature: _____

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