

Coronavirus Disease (COVID-19)

MSCC Childcare Health Screening

(Based on WCHD updates as of July 2020)

Name: _____ Class: _____

In the past 24 hours, have YOU, YOUR CHILD, or CHILD'S SIBLINGS experienced:

DATE:					
Fever:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
New or worsening cough: (even if we suspect it is caused by a runny nose)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Shortness of breath:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sore Throat:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diarrhea:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fatigue and Body Aches:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Temperature:	_____	_____	_____	_____	_____

If you answered "yes" to any of the symptoms listed above, or temperature is 100.4 or higher, please don't go into school. Self-isolate at home & contact primary care physician for direction.

If your child only has a runny nose, you may send them to school.

If your child develops a cough due to the runny nose then you must keep your child, and any siblings home, until symptom free for 72 hours.

You must have 3 days without fevers & improvement in respiratory & other symptoms, before returning.

You should isolate at home for a minimum of 7 days since symptoms first appear, in the case of multiple multiple symptoms, AND be symptom free for 72 hours before returning to school.

In the case when a diagnosis has been made from a doctor, with a note (ie: ear or sinus infection, food allergy, etc.) contact administration for guidance.

In the past 14 days, have you or your child:

Had close contact with an individual diagnosed with COVID-19?

Yes No | Yes No | Yes No | Yes No | Yes No

Travelled via airplane internationally or domestically?

Yes No | Yes No | Yes No | Yes No | Yes No

If you answered "yes" to either of these questions, please do not come to school. Self-quarantine for 14 days.

In the past 14 days, have you or your child:

Traveled out-of-state via automobile?

Yes No | Yes No | Yes No | Yes No | Yes No

If you answered "yes", please do not come to school for 72 hours AFTER you return home.