ST. ROSE OF LIMA SCHOOL
WARWICK, RHODE ISLAND

COVID-19 SCREENING TOOL

Student's Name _____Homeroom Teacher_____

Check any of the symptoms in the following boxes **A** and **B** that your student has experienced in the past three day that are not explained by allergies or non-infectious cause. Check all that apply.

A.

- ☐ Cough
- ☐ Shortness of breath
- ☐ Difficulty breathing
- ☐ New loss of taste or smell

B.

- ☐ Fever
- ☐ Chills
- ☐ Muscle aches (myalgias)
- ☐ Headache
- ☐ Sore throat
- ☐ Nausea or Vomiting
- ☐ Diarrhea
- ☐ Fatigue
- ☐ Congestion or runny nose

- Has your student been in close contact (less than 6 feet for more than 15 minutes) with anyone with COVID-19? Yes ____ No ____
- Has your students traveled anywhere outside the 50 United States in the past 14 days? Yes ____ No ____
- Has your student be directed to quarantine or isolate by the RI Department of Health or a healthcare provider in the past 14 days? Yes____ No ____

Temperature _____

If your student has any **one** of the symptoms from box **A** or any **two** of the symptoms from box **B** in the past three day that are not explained by allergies or non-infectious cause or you have answered **Yes** to any of the above questions, then your student cannot enter the school for the safety of others.

Parent/Guardian signature or initials _____

Date_____

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