COVID-19
SELF-SCREENER CHECKLIST

In the past 14 days, have you been in **close contact with anyone who has been diagnosed with COVID-19** or exhibited symptoms associated with COVID-19 (fever of 100.4 or higher, cough, shortness of breath)?

Have you been **advised by a doctor** or healthcare provider **to stay home** or otherwise avoid contact with others?

In the past 24 hours, have you **experience** any of the **following symptoms?**

- ❍ **Fever of 100.4 or higher or Chills**
- ❍ **Cough, Shortness of Breath or Difficulty Breathing**
- ❍ **Headache, Muscle or Body Aches**
- ❍ **Sore Throat**
- ❍ **New Loss of Taste or Smell**
- ❍ **Fatigue**
- ❍ **Congestion or Runny Nose**
- ❍ **Diarrhea, Nausea or Vomiting**

In the past 14 days, have you **traveled** via plane, mass transportation, or to/from any **areas with a CDC travel advisory?**

BE SURE TO WEAR FACE COVERINGS PROPERLY

FACE COVERINGS REQUIRED

SCHOOL DISTRICT OF FORT·ATKINSON