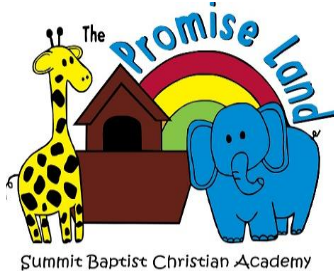

At home Self Screening Questionnaire

Please complete DAILY at home prior to school!!

	Yes	No
1. Has anyone in your household tested positive for COVID-19?		
2. Have you or anyone in your household been in contact with someone who is presumptive positive or has tested positive for COVID-19?		

3. Have you or your child experienced any of the following

	Yes	**No**
Fever		
Cough		
Shortness of breath or difficulty breathing		
Chills		
Repeated shaking with chills		
Muscle pain		
Headache		
Sore Throat		
Vomitting		
Diarrhea		
New loss of taste or smell		
Rash		

If you answered **YES** to any of the above questions please remain at home.

Thank you so much for helping us keep the students and staff safe here at SBCA!