University Primary School
Symptom Screening Form

Date______________Grade Level______________________

Student Name_______________________________________

1. What date was your child's last COVID test?________________________
2. What date was the result of that test?____________________
3. Was the result negative? _______________________(Please submit test result PDF to cwyant@illinois.edu)

In the past 24 hours has your child experienced:

Yes	No	
		Fever (100.4 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?

Parent/Guardian Signature:____

To be completed at school - Temperature ______________

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