Talmudical Academy

Staff: COVID Symptom Screening

Name: _____ Grade:_____ Date:_____

Please complete this form each morning before you leave for school. You will not be allowed into school without it.

			NO	YES
Have you **tested positive with Covid-19** within the past 10 days?				
Current temperature:		Have you had a fever of 100.4 F within the last 24 hours or symptoms of **new onset of cough, shortness of breath, difficulty breathing or loss of sense of taste or smell**?		
Do you have at least **2** of the following: chills, shivering, muscle pain, sore throat, headache, and gastrointestinal symptoms (nausea, vomiting or diarrhea), fatigue and congestion or runny nose?				
Have you had close contact (within 6 feet for at least 15 minutes) to anyone with suspected or confirmed Covid-19 within the past 14 days?				
Have you participated, unmasked, in a large gathering with people in close proximity (most simchas fit this definition) in the past 10 days?				

If you answer "Yes" *to any of these questions,* ***do not come to school and call the school for further directions****. Please do not write anything else on this form.*

I, listed below, certify the following information is true to the best of my knowledge as of:

Date:_____ Time:_____ Signature:_____