Dear parents and guardians;

Please complete this assessment at home every day prior to your son/daughter going to school in the morning.

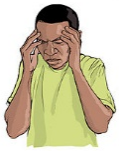
Does your son/daughter have any of these symptoms?

Cough

Congestion or runny nose

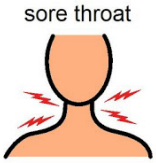
Chills/Fever

Headache



Muscle pain (with no reason)

Sore throat



Loss of taste or smell

Digestive problems

Is your son/daughter's temperature above 99.9 degrees Fahrenheit?

Yes _____ No _____

Have they traveled to any of the restricted states published by the PA DOH in the last 14 days?

Yes _____ No _____

Have they or anyone in your household been instructed to quarantine or been in close contact with a person who was diagnosed with COVID-19 or been instructed to quarantine with symptoms of COVID -19 in the past 14 days?

Yes _____ No _____

If you answered yes to any of these questions, please stay home and contact your school nurse and your son/daughter's doctor.