## **Chancellor Academy**

## COVID-19 Daily Screening for Students

Parents/Guardians: Please complete this short check each morning and report your child's information to the school nurse.  Section 1: Symptoms  Any of the symptoms below could indicate a COVID -19 infection in children and may put your child at risk for spreading illness to others. Please note that this list does not include all possible symptoms and children with COVID-19 may experience any, all, or none of these symptoms. Please check your child daily for these symptoms:  Column A  Column B  Column B  Column B  Cough Shortness of Breath Difficulty Breathing New loss of smell New loss of smell New loss of state New loss of state Fever (measured or subjective)  Fatigue Congestion or runny nose  If TWO OR MORE of the fields in Column A are checked off OR AT LEAST ONE field in column B is checked off, please keep your child home and notify the school for further instructions.  Section 2: Close Contact/Potential Exposure  Please verify if:  Your child has had close contact (within 6 feet of an infected person for at least 10 minutes) with a person with confirmed COVID-19 Someone in your household is diagnosed with COVID-19 Someone in your household is diagnosed with COVID-19 Your child has traveled to an area of high community transmission. Visit covid19:nj.gov  If ANY of the fields in Section 2 are checked off, your child should remain home for 14 days from the last date of exposure (if child is a close contact of a confirmed COVID-19 case) or date of return to New Jersey.  Contact your child's provider or your local health department for further guidance.  Name of Person Completing Form:	Student Name			Date				
Any of the symptoms below could indicate a COVID -19 infection in children and may put your child at risk for spreading illness to others. Please note that this list does not include all possible symptoms and children with COVID-19 may experience any, all, or none of these symptoms. Please check your child daily for these symptoms:    Column A	-	•	ort check	each mornin	g and report your child's			
risk for spreading illness to others. Please note that this list does not include all possible symptoms and children with COVID-19 may experience any, all, or none of these symptoms. Please check your child daily for these symptoms:  Column A  Column B  Cough  Shortness of Breath  New loss of smell  New loss of smell  New loss of smell  Rigors (shivers)  Diarrhea  Fatigue  Congestion or runny nose  If TWO OR MORE of the fields in Column A are checked off OR AT LEAST ONE field in column B is checked off, please keep your child home and notify the school for further instructions.  Section 2: Close Contact/Potential Exposure  Please verify if:  Your child has had close contact (within 6 feet of an infected person for at least 10 minutes) with a person with confirmed COVID-19  Someone in your household is diagnosed with COVID-19  Someone in your household is diagnosed with COVID-19  Nour child has traveled to an area of high community transmission. Visit covid19.nj.gov  If ANY of the fields in Section 2 are checked off, your child should remain home for 14 days from the last date of exposure (if child is a close contact of a confirmed COVID-19 case) or date of return to New Jersey.  Contact your child's provider or your local health department for further guidance.  Name of Person Completing Form:	Section 1	L: Symptoms						
Chills   Sigors (shivers)   Shortness of Breath   Shortness of Breath   Difficulty Breathing   New loss of smell   New loss of smell   New loss of taste   Fever (measured or subjective)   Fever (measured or subjective)   TWO OR MORE of the fields in Column A are checked off OR AT LEAST ONE field in column B is checked off, please keep your child home and notify the school for further instructions.  Section 2: Close Contact/Potential Exposure  Please verify if:  Your child has had close contact (within 6 feet of an infected person for at least 10 minutes) with a person with confirmed COVID-19  Someone in your household is diagnosed with COVID-19  Your child has traveled to an area of high community transmission. Visit covid19.nj.gov  If ANY of the fields in Section 2 are checked off, your child should remain home for 14 days from the last date of exposure (if child is a close contact of a confirmed COVID-19 case) or date of return to New Jersey.  Contact your child's provider or your local health department for further guidance.  Name of Person Completing Form:	risk for sp children v daily for t	reading illness to others. Please note vith COVID-19 may experience any, al hese symptoms:	that this	list does not e of these sy	include all possible symptoms and			
Rigors (shivers)  Myalgia (muscle aches)  Headache  New loss of smell  New loss of taste  Fever (measured or subjective)  If TWO OR MORE of the fields in Column A are checked off OR AT LEAST ONE field in column B is checked off, please keep your child home and notify the school for further instructions.  Section 2: Close Contact/Potential Exposure  Please verify if:  Your child has had close contact (within 6 feet of an infected person for at least 10 minutes) with a person with confirmed COVID-19  Someone in your household is diagnosed with COVID-19  Your child has traveled to an area of high community transmission. Visit covid19.nj.gov  If ANY of the fields in Section 2 are checked off, your child should remain home for 14 days from the last date of exposure (if child is a close contact of a confirmed COVID-19 case) or date of return to New Jersey.  Contact your child's provider or your local health department for further guidance.  Name of Person Completing Form:	Column A	\ 	ĺ	Column B				
Myalgia (muscle aches)		Chills			Cough			
Headache		Rigors (shivers)			Shortness of Breath			
New loss of taste   Fever (measured or subjective)     Diarrhea   Fatigue   Congestion or runny nose     If TWO OR MORE of the fields in Column A are checked off OR AT LEAST ONE field in column B is checked off, please keep your child home and notify the school for further instructions.  Section 2: Close Contact/Potential Exposure		Myalgia (muscle aches)			Difficulty Breathing			
Nausea or Vomiting		Headache			New loss of smell			
Diarrhea		Sore Throat			New loss of taste			
Fatigue Congestion or runny nose  If TWO OR MORE of the fields in Column A are checked off OR AT LEAST ONE field in column B is checked off, please keep your child home and notify the school for further instructions.  Section 2: Close Contact/Potential Exposure  Please verify if:  Your child has had close contact (within 6 feet of an infected person for at least 10 minutes) with a person with confirmed COVID-19 Someone in your household is diagnosed with COVID-19 Your child has traveled to an area of high community transmission. Visit covid19.nj.gov  If ANY of the fields in Section 2 are checked off, your child should remain home for 14 days from the last date of exposure (if child is a close contact of a confirmed COVID-19 case) or date of return to New Jersey.  Contact your child's provider or your local health department for further guidance.  Name of Person Completing Form:		Nausea or Vomiting			Fever (measured or subjective)			
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Please Print Signature	last date of New Jerse Contact y	of exposure (if child is a close contact ey.  our child's provider or your local heal	of a conf	irmed COVII	0-19 case) or date of return to			
	Please Pri	int		Signature				