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COVID-19 Daily Screening for Students

Name _____ Date _____

Parents/Guardians: Please complete this short checklist each morning and report your child's information. Contact Vanessa Arroyo, school nurse at Varroyo@rps1.org before 8:00am daily.

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

- Fever (measured or subjective)
- Chills
- Rigors (shivers)
- Myalgia (muscle aches)
- Headache
- Sore Throat
- Nausea or Vomiting
- Diarrhea
- Fatigue
- Congestion or runny nose

Column B

- Cough
- Shortness of Breath
- Difficulty Breathing
- New loss of smell
- New loss of taste

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:

<input type="checkbox"/>	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
<input type="checkbox"/>	Someone in your household is diagnosed with COVID-19
<input type="checkbox"/>	Your child has traveled to an area of high community transmission .

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.