COVID-19 Student Health Screening
Hillsdale Community Schools

Student name: _____ Date: _____

Grade: _____ Temp:_____ Time: _____

Students with any of the following symptoms (new/different/worse from baseline of any chronic illness) should be excluded from school and encouraged to follow up with their healthcare provider:

ONE of the following:
____ Feverish (100.4 or above)
____ Cough
____ Shortness of breath
OR TWO of the following:
____ Muscle aches without another explanation
____ Chills
____ Sore throat
____ Headache
____ Vomiting or Diarrhea
____ Loss of taste or smell

Have you had exposure to Covid-19 in the last 10 days? Yes _____ No _____

Parent/Guardian: _____ Date _____

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