Name _____ **Phone** _____ **Room**___

COVID-19 Screening

The safety of our community is our overriding priority. As the coronavirus (COVID-19) pandemic continues, we are monitoring the situation closely and following the guidance from the Centers for Disease Control and the Department of Education. In order to prevent the spread of the coronavirus and reduce the potential risk of exposure to our school, we are asking everyone to complete and submit this questionnaire prior to returning to school. Please do not enter the building until your responses have been reviewed and your entry has been approved.

Please respond to each of the following questions truthfully and to the best of your ability. Your participation is important to help us take precautionary measures to protect you and the MLM community.

1. Are you or any member of your household currently experiencing, or have you experienced in the past 14 days, any of the following symptoms? (***Please take your temperature before you answer this question.)***

Symptom	Yes, within the last 14 days	Yes, within 24 hours	No
Fever (100.4° F/37.8° C or greater as measured by an oral thermometer)			
Fatigue			
?Cough			
Sneezing			
Aches and Pains			
Runny or Stuffy Nose			
Sore throat			
Diarrhea, vomiting or nausea			
Headaches			
Shortness of breath			
New loss of taste or smell			
Chills			

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2	Yes	No	In the past 14 days, have you or any member of your household been in close proximity to anyone who was experiencing any of the above symptoms or has experienced any of the above symptoms since your contact?
3	Yes	No	In the past 14 days, have you or any member of your household recently been in contact with anyone who has tested positive for COVID-19?
4	Yes	No	Have you or any member of your household been tested for COVID-19 and are waiting to receive test results?
5	Yes	No	Have you or any member of your household tested positive for COVID-19, or are you presumptively positive for COVID-19 based on your health care provider's assessment or your symptoms? **NOTE**: If you have tested positive for COVID-19 or have been presumptively positive for COVID-19 based on your health care provider's assessment or your symptoms, please contact the school office 412-563-2858: (1) you have had no fever for at least 72 hours (3 full days), without the use of fever-reducing medications; (2) your other symptoms have improved; **and** at least 7 days have elapsed since your symptoms first appeared.
6	Yes	No	In the past 14 days, have you or any member of your household been on a commercial flight, cruse, visited a hot zone or traveled outside of the United States?
7	Yes	No	In the past 14 days, have you or any member of your household been in close proximity to anyone who has been on a commercial flight, cruse, visited a hot zone or traveled outside of the United States?
8	Yes	No	Is there any reason why you feel you are at higher risk of contracting COVID-19 or experiencing complications from COVID-19 by entering the facility? If "yes", please provide a brief explanation.

I hereby certify that the responses provided above are true and accurate to the best of my knowledge.

Signature: _____ Date: _____

Note: The information collected on this form will be used to determine only whether you may be infected with COVID-19. Changes to the information on this form must be reported. The information on this form will be maintained as confidential. Any questions should be directed to the office 412-563-2858.

Access to building (circle one): Approved Denied