JORDAN SCHOOL DISTRICT

Name: _____ **School:** _____ **Month:** _____

Instructions: School students and employees must undergo a symptom check prior to coming to school. Please check your symptoms at home, select Y=Yes and N=No and record. If you answer **YES** to any of the below questions, you must stay home. For weekends draw a line through the date. If you have questions please contact your school nurse.

Date	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Exposure to COVID-19 in the past 10 days?																															
Are you feeling ill?																															
Record Temperature. If 100.4 or higher stay home																															
Cough Short of Breath Difficulty Breathing Chills Fatigue Muscle or Body Ache Congestions/Runny Nose Sore Throat Headache New loss of taste or Smell Nausea or Vomiting/Diarrhea																															