Parents Name:_____ Date:_____
Childs Name:_____

Visual Inspection:
Temperature (100 degrees or more): _____
Shortness of Breath:_____
Cough:_____
Fatigue:____
Irritability:_____

Self Inspection:
Has your child had any of the following symptoms in the past 24 hours?
Please Answer Y for Yes and N for No!
Cough: _____
Sore Throat:_____
Difficulty Breathing: ____
Abdominal Pain:___
Nausea:_____
Diarrhea:____
Vomiting:___
Unexplained Rash:_____
Fatigue:_____
Headache:___
Loss of Smell/Taste:_____
Muscle Aches:_____
Any other Signs of Illness? If Yes,
what?_____
_____