Form 1:

Return to School Screening

1. Is your child experiencing any of the following symptoms?
   - ❑ Cough — Yes _____ No _____
   - ❑ Fever (greater than 100.4 F) — Yes _____ No _____
   - ❑ Sore throat — Yes _____ No _____
   - ❑ Shortness of breath — Yes _____ No _____

   *(Others symptoms may be added before the beginning of school starts)

2. Have you had contact with anyone exposed to COVID-19 or who has tested positive for COVID-19?

   Yes __________ No ________

3. Have you engaged in international travel within the last 14 days or traveled out of Pennsylvania or New Jersey*?

   Yes __________ No ________

   If yes, where? ______________________________________

4. Your temperature reading today August 31, 2020 is: ________ F

Name:___________________________________ Date: ___________________

* New Jersey is included because we have students that reside in the state of New Jersey.