BEFORE SCHOOL SCREENING

Completed DAILY prior to school

1. Is the student taking any medications to treat or reduce a fever such as Ibuprofen (i.e. Advil, Motrin) or Acetaminophen (Tylenol)?

2. Is the student experiencing any of the following?

GROUP A *ONE or more symptoms*	**GROUP B** *TWO or more symptoms*
Cough* Shortness of Breath Difficulty Breathing New olfactory disorder New taste disorder ** For students with a chronic allergic/asthmatic cough, a change in their baseline cough*	Fever *(measured or subjective)* Chills Rigors Myalgia Sore throat Nausea or vomiting Diarrhea Fatigue Congestion or runny nose

3. List daily and track any medications and symptoms on the calendars.

STAY HOME IF THE STUDENT HAS:

- One or more symptoms in Group A **OR**
- Two or more symptoms in Group B **OR**
- Taken fever reducing medication

VISIT www.EASDPA.ORG/COVIDSYMPTOMS FOR MORE INFORMATION.

SEPTEMBER

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
31	1	2	3	4
7	8	9	10	11
14	15	16	17	18
21	22	23	24	25
28	29	30		

OCTOBER

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
			1	2
5	6	7	8	9
12	13	14	15	16
19	20	21	22	23
26	27	28	29	30

NOVEMBER

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
2	3	4	5	6
9	10	11	12	13
16	17	18	19	20
23	24	25	26	27
30				