Daily COVID-19 Screening

*This form must be completed every day for your child to enter the program

Must be handed in at check in every morning

Name_____ Today's Date_____

Does your child have any of the following?:

Yes____ No_____ Fever (above 100.4)

Yes____ No_____ New loss of taste or smell?

Yes____ No_____ New and persistent cough?

Yes____ No_____ Shortness of breath or any difficulty breathing

Yes____ No_____ Come in contact with any one in the last 14 days experiencing these symptoms

Yes____ No_____ Come in contact with anyone who has tested positive in the last 14 days

Yes____ No_____ Has your child or any household member traveled to any "hot spot" States within in the last 14 days

If you have answered yes to any of the following , you are unable to attend SONCCA. We as that you either self quarantine for 14 days, or provide a negative Covid-19 test.

Parent Signature:_____

Daily COVID-19 Screening

*This form must be completed every day for your child to enter the program

Must be handed in at check in every morning

Name_____ Today's Date_____

Does your child have any of the following?:

Yes____ No_____ Fever (above 100.4)

Yes____ No_____ New loss of taste or smell?

Yes____ No_____ New and persistent cough?

Yes____ No_____ Shortness of breath or any difficulty breathing

Yes____ No_____ Come in contact with any one in the last 14 days experiencing these symptoms

Yes____ No_____ Come in contact with anyone who has tested positive in the last 14 days

Yes____ No_____ Has your child or any household member traveled to any "hot spot" States within in the last 14 days

If you have answered yes to any of the following , you are unable to attend SONCCA. We as that you either self quarantine for 14 days, or provide a negative Covid-19 test.

Parent Signature:_____