Tioga ISD Health Screening Form

First name _____ Last Name _____

Physical address_____

City, State, Zip_____

Phone Number_____

1. Today or in the past 24 hours have you had any of the following:

Temperature 100.4 (under age 65) and 99.5 (65 and older)	YES	NO
Fever		
Cough		
Runny nose		
Sneezing		
Sore throat		
Headache		
Muscle aches		
Chills		
Fatigue		
Malaise (feeling unwell)		
Chest pain		
Shortness of breath		
Difficulty breathing		
Inability to keep liquids down because of vomiting		
Diarrhea		
Loss of taste and/or smell		

2. In the past 14 days, have you had contact with a person known to be infected with the novel coronavirus (COVID-19)?

YES	NO

3. Have you traveled to any "hot spot" areas within the past 14 days? (New York, New Jersey, Massachusetts , California, etc.)

YES	NO

4. Do you have a sick family member at home with any of the above symptoms?

YES	NO

Name of graduating student you came to watch: _____

I certify the information provided above is accurate and true.

Signature: _____Date: _____
(Signature of Parent/Guardian if visitor is under 18 years old).