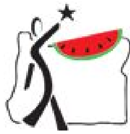

Hermiston School District COVID-19 Screening Form

DO NOT COME TO CAMPUS IF:
You have a temperature of 100.4° F or more.
Have been exposed within the last 14 days to someone diagnosed with COVID-19.
Have been exposed within the last 14 days to someone with symptoms of COVID-19.
Have symptoms of COVID-19 yourself.

Date:______________________ Time: ______________________ Location: _______________________________

Name:____ Phone: __________________________________

Address:____

Emergency Contact Name:_______________________________________ Phone:___________________________

1. What is your current temperature? ___________ ^{0}F

2. Have you had Tylenol (acetaminophen) or Advil (ibuprofen) in the last **24 hours**?

   Yes______ No______

3. In the past **14 days** have you been exposed to someone diagnosed with COVID-19, or someone who exhibits any of the following symptoms: fever, cough, shortness of breath or difficulty breathing, chills, repeated shaking with chills, muscle pain, headache, sore throat, or new loss of taste or smell?

   Yes ______ No ______

4. In the past **48 hours** have you had any of the following symptoms:

Cough	Yes ____ No ____	Shortness of Breath	Yes ____ No ____
Difficulty Breathing	Yes ____ No ____	Shaking/Chills	Yes ____ No ____
Muscle Pain	Yes ____ No ____	Headache	Yes ____ No ____
Sore Throat	Yes ____ No ____	Loss of Taste or Smell	Yes ____ No ____
Diarrhea	Yes ____ No ____	Feverish/Temp **over** 100.3^{0} F	Yes ____ No ____

Please **clean your hands** prior to entering the facility, maintain a **social distance of 6 feet**, and consider wearing a face covering when not exercising.

*This form is to be submitted to HSD staff and maintained for a minimum of 4 weeks after completion of limited in-person instruction or summer school.

05/2020