BISHOP ALEMANY HIGH SCHOOL
COVID-19 QUESTIONNAIRE
PARENT/GUARDIAN

DATE:_____TEMPERATURE:_____

PLEASE ANSWER YES/NO TO THE FOLLOWING:

- **IN THE PAST 14 DAYS HAVE YOU EXPERIENCED:**

FEVER	YES_____NO_____
COUGH	YES_____NO_____
SOAR THROAT	YES_____NO_____
SHORTNESS OF BREATH	YES_____NO_____
FATIGUE	YES_____NO_____
DIARRHEA	YES_____NO_____
VOMITTING	YES_____NO_____
HEADACHES	YES_____NO_____
CHILLS	YES_____NO_____
BODY ACHES/PAINS	YES_____NO_____

- **IN THE PAST 14 DAYS**,
  - HAVE YOU BEEN EXPOSED TO ANYONE EXPERIENCING THE SIGNS OR SYMPTOMS ABOVE?
    YES_____NO_____
  - HAVE YOU TRAVELED ANYWHERE?
    YES_____NO_____
    IF YES, WHERE?
  - HAVE YOU BEEN EXPOSED TO ANYONE WHO HAS TRAVELED IN THE LAST 14 DAYS?
    YES_____NO_____
  - HAVE YOU BEEN TESTED FOR COVID-19
    YES_____NO_____ (IF YES:RESULTS_____)
  - HAVE YOU BEEN EXPOSESD TO ANYONE WHO HAS TESTED POSITIVE (+) FOR COVID-19?
    YES_____NO_____
  - HAS ANYONE IN YOUR IMMEDIATE HOUSEHOLD BEEN DIAGNOSED WITH COVID-19?
    YES_____NO_____

I _____ (PLEASE PRINT) HAVE READ, UNDERSTOOD AND ANSWERED THE ABOVE QUESTIONS TO THE BEST OF MY KNOWLEDGE.

SIGNATURE_____DATE_____