COVID-19 Daily Self-Checklist

Name:____ Date:________________________

Review this COVID-19 Daily Checklist each day before bringing your child to our center. If you reply YES to any of the questions below, STAY HOME and contact your Family Advocate.

Has your family recently traveled (within the past 14 days) from states with high rates of COVID-19 infection? https://coronavirus.health.ny.gov/covid-19-travel-advisory

☐Yes ☐No State _____________________________________

Does your child and anyone in your household have a fever (temperature over 100°F) without having taken any fever reducing medications?

☐Yes ☐No

Has your child or anyone in your household experienced any of the following symptoms?

Muscle aches? ☐Yes ☐No Cough? ☐Yes ☐No Sore throat? ☐Yes ☐No

Headache? ☐Yes ☐No Shortness of breath? ☐Yes ☐No Chills? ☐Yes ☐No

Loss of smell or taste? ☐Yes ☐No

Has your child or anyone in your household experienced any gastrointestinal symptoms such as nausea/ vomiting, diarrhea, loss of appetite?

☐Yes ☐No

Has anyone in your household been in close contact with someone who has been diagnosed with COVID-19, or experienced symptoms of COVID-19?

☐Yes ☐No

Has anyone in your household tested positive for COVID-19 in the past 14 days?

☐Yes ☐No

Has anyone in your household had any symptoms of COVID-19 in the past 14 days? (flushed skin, breathing difficulty, rapid breath breathing, etc.)

☐Yes ☐ No