Child Health Screening Form
Parkside Children's Learning Center

Child's Name: _____ Date: _____

Symptoms of COVID-19: Cough, Shortness of breath or difficulty breathing, Fever, Chills, Repeated shaking with chills, Muscle or body aches, Headache, Sore throat, New loss of taste or smell, Congestion or runny nose, Nausea or vomiting, Diarrhea

Please answer the following questions to the best of your ability:

- Does your child have any symptoms of COVID-19 listed above? **Y or N**
- Has your child or anyone in your household traveled outside of ME, NH, NY, CT, NJ, or VT in the past month? **Y or N**
- Has your child come into contact with anyone who has tested positive for COVID-19? **Y or N**
- Is anyone in your child's household experiencing signs of illness? **Y or N**
- Child's temperature: _____
- Parent signature (agreeing information is correct): _____
- Parkside staff person initials: _____

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