Student Health Screener

The Screener should be completed by going to student.risd.org
Only use this form if you are unable to access **student.risd.org**.

Student First Name: ______________________ Student Last Name: ______________________

Teacher: ______________________________ School: ______________________________

In the past 14 days, has your child had known, prolonged (more than 15 minutes), close contact (within 6 feet) with a person who has tested positive for COVID-19 or is suspected of having COVID-19?

☐ Yes – **Please keep your child home and contact your campus nurse.**
☐ No

In the past 24 hours, has your child had any of the following **NEW or WORSENING** symptoms?

- Feeling feverish or a measured temperature greater than or equal to 100.0 F?
- Loss of taste or smell
- Cough
- Difficulty breathing
- Shortness of breath
- Fatigue
- Headache
- Chills/repeated shaking with chills
- Sore throat
- Shaking or exaggerated shivering
- Significant muscle pain or ache
- Diarrhea
- Nausea or vomiting

☐ Yes – **Please keep your child home and contact your campus nurse.**
☐ No

Please list temperature (°F) taken at home: ____________
(Please keep child at home if temperature is greater than or equal to 100.0 F.)

Please keep your child home if he or she has any of the above symptoms and contact your campus nurse.

Signature of Parent/Guardian: ____

Date: ____

By submitting this form, I certify that the information I am providing is true and correct.