Rahway Public Schools

Dear Parent/Guardian:

To support the health and wellness of our school community, we ask that you answer the following questionnaire daily and confirm that all answers are **NO.** If you have answered yes to any questions you **must** keep your child home and contact the school nurse.

These questions help us to determine the health and wellness of each member of our school community.

COVID- 19 DAILY QUESTIONNAIRE

(Please answer Yes or No to the questions asked below)

My child has one or more of the following symptoms:
(Check all that apply)

☐ **NONE**
☐ Fever or chills
☐ Cough
☐ Shortness of breath or difficulty breathing
☐ Fatigue
☐ Muscle or body aches
☐ Headache
☐ New loss of taste or smell
☐ Sore throat
☐ Congestion or runny nose
☐ Nausea or vomiting
☐ Diarrhea

1. **My child or a member of my household has been diagnosed with COVID-19 In the last 3 weeks?**
   Circle One: Yes No

2. **My child or a member of my household has traveled out of the state within the past 2 weeks ?**
   Circle One: Yes No

Contact your School Nurse if any answer is “yes”