



Fairfax County

PUBLIC SCHOOLS

ENGAGE • INSPIRE • THRIVE

COVID-19 Health Screening Questions to be completed daily by a parent/guardian, staff member or essential visitor

Staff and Students should remain at home if any of the responses are 'YES'

Essential visitors will not be permitted into FCPS facilities if any of the responses are 'YES'

YES or NO, since your last day of school/work/visitation have you had any of the following symptoms?	Yes	No
Feeling feverish and/or having chills –documented temperature of 100.4°F or higher?	<input type="checkbox"/>	<input type="checkbox"/>
Has there been any use of fever reducing medication within the last 24 hours?	<input type="checkbox"/>	<input type="checkbox"/>
A new cough that is not due to another health condition?	<input type="checkbox"/>	<input type="checkbox"/>
Nasal congestion or runny nose	<input type="checkbox"/>	<input type="checkbox"/>
New shortness of breath or difficulty breathing that is not due to another health condition?	<input type="checkbox"/>	<input type="checkbox"/>
New chills that are not due to another health condition?	<input type="checkbox"/>	<input type="checkbox"/>
A new sore throat that is not due to another health condition?	<input type="checkbox"/>	<input type="checkbox"/>
New muscle aches that are not due to another health condition, or that may have been caused by a specific activity (such as physical exercise)?	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue (more tired than usual)?	<input type="checkbox"/>	<input type="checkbox"/>
Headache?	<input type="checkbox"/>	<input type="checkbox"/>
A new loss of taste or smell?	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal pain, diarrhea, nausea or vomiting?	<input type="checkbox"/>	<input type="checkbox"/>
New onset of poor appetite or poor feeding?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a positive test for the virus that causes COVID-19 disease within the past 10 days?	<input type="checkbox"/>	<input type="checkbox"/>
Were you currently tested for COVID-19 because you were sick and are still waiting for the lab results?	<input type="checkbox"/>	<input type="checkbox"/>
In the past 14 days, have you had close contact (within about 6 feet for 15 minutes or more) with someone with suspected or confirmed COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>

Print Name

Signature

Date