MINERSVILLE AREA SCHOOL HEALTH SERVICES

MINERSVILLE AREA SCHOOL DISTRICT ------ COVID -19 SYMPTOM SCREENING TOOL

Complete Daily Prior to School/Work*

Employee or Student Name: _____ Date: _____

Temperature: _____ Taken by: (Mouth – Under arm – Ear – Forehead Scan)

Are you taking any medication to treat or reduce a fever such as Ibuprofen (i.e. Advil, Motrin) or Acetaminophen (Tylenol)? YES NO

Have you been diagnosed or presumed to have COVID-19? YES NO

Have you had close contact (been within 6 feet for at least 15 minutes) with someone who has either a confirmed or suspected case of COVID-19? YES NO

Have you traveled outside of Schuylkill County within the past 2 weeks? YES NO

If so where? _____ If you have been to an area with high case numbers, please stay home and contact your physician or health department for further direction.

Are you experiencing any of the following? (Please circle ALL that apply)

Group A **1 or more symptoms**	**Group B** **2 or more symptoms**
Cough	Fever (measured or subjective)
Shortness of breath	Chills
Difficulty breathing	Rigors (sense of cold/shivers with rise in temp)
New olfactory disorder (loss of sense of smell)	Myalgia (muscle aches/soreness)
New taste disorder	Headache
Temperature of 100.4 or greater	Sore throat
	Nausea or vomiting
	Diarrhea
	Fatigue
	Congestion or runny nose

Stay home if, you or the student:

- Have answered yes to any of the above questions **OR**
- Have **one or more** symptoms in Group A **OR**
- Have **two or more** symptoms in Group B **OR**
- Are taking fever reducing medication.