WEEKLY PAL YOUTH HEALTH QUESTIONAIRE

1. Has your child had any signs or symptoms of a fever in the past 24 hours such as chills, sweats, felt "feverish" or had a temperature that is elevated for you/100.0F or greater?

   YES: _____ NO: _____

2. Does your child have any of the following symptoms?

   - Cough
   - Shortness of Breath or Chest Tightness
   - Sore Throat
   - Nasal Congestion/Runny Nose
   - Myalgia (Body Aches)
   - Loss of Taste and/or Smell
   - Diarrhea
   - Nausea
   - Vomiting
   - Fever/Chills/Sweats

   YES: _____ NO: _____

3. Has your child traveled internationally or outside of state in the last 14 days? Or, has your child had any close contact in the last 14 days with someone with a diagnosis of COVID-19?

   YES: _____ NO: _____

4. Has your child been experiencing symptoms or been asked by a doctor to take a test for COVID-19 but still waiting for the results?

   YES: _____ NO: _____

Name of Child: _____

Name of Parent/Guardian:_____

Signature of Parent/Guardian:_____ Date: _____