

Active Learning Centers COVID-19 Health Screening

Student: _____ **Date:** _____

Have you/your child been confirmed positive for COVID-19?

Are you/your child experiencing or recently experienced any acute respiratory illness symptoms such as fever or cough or shortness of breath?

Have you/your child been in close contact with any person who has been confirmed positive for COVID-19?

Have you/your child been in close contact with any persons who have traveled and are also exhibiting acute respiratory illness symptoms?