ERSKINE ACADEMY
SINCE 1883

COVID-19 - Erskine Academy High School Daily Screening Tool

Today or in the past 24 hours have you had any of the following:

YES or NO **Date:**	X	X	8/3	8/4	8/5	8/6	8/7
Fever							
New Cough							
Runny nose							
Sneezing							
Sore throat							
Headache							
Muscle aches							
Chills							
Fatigue							
Malaise (feeling unwell)							
Chest pain							
Shortness of breath							
Difficulty breathing							
Inability to keep liquids down because of vomiting							
Diarrhea							
Loss of taste and/or smell							

YES or NO **Date:**	X	X	8/3	8/4	8/5	8/6	8/7
In the past 14 days have you had contact with a person known to be infected with the novel coronavirus (COVID-19)?							
Have you traveled to any "hot spot" area within the past 14 days?							
Do you have a sick family member at home with any of the above symptoms?							

****REPORT ANY "YES" RESPONSES TO THE ABOVE QUESTIONS TO YOUR COACH, ATHLETIC TRAINER, SCHOOL NURSE, OR ATHLETIC DIRECTOR, WHO MAY ASK FOR CLARIFICATION OF YOUR ANSWERS.****

NAME: _____ **TEAM:** _____