Appendix B
Covid-19 Screening Checklist

Daily Screening Tool

1. Today or in the past 24 hours have you had any of the following that are unrelated to a known non-contagious condition:

Fever (100.4 or higher) or chills	YES	NO
Cough	YES	NO
Runny nose or nasal congestion	YES	NO
Sore throat	YES	NO
Headache	YES	NO
Muscle aches	YES	NO
Fatigue	YES	NO
Shortness of breath	YES	NO
Difficulty breathing	YES	NO
Vomiting	YES	NO
Diarrhea (3 or more loose stools)	YES	NO
Loss of taste and/or smell	YES	NO

2. In the past 14 days, have you had close contact with a person with presumed or known infection with (COVID-19)?

   YES NO

3. Have you traveled outside the State of Maine within the past 14 days?

   YES NO

4. Do you have a sick family member at home with any of the above symptoms?

   YES NO

****STUDENTS/PARENTS:** REPORT ANY "YES" RESPONSES TO THE ABOVE QUESTIONS TO YOUR SCHOOL NURSE, WHO MAY ASK FOR CLARIFICATION OF YOUR ANSWERS. ****EMPLOYEES:** REPORT ANY "YES" RESPONSES TO YOUR ADMINISTRATOR OR SUPERVISOR, WHO MAY ASK FOR CLARIFICATION OF YOUR ANSWERS.**