PRINCE GEORGE COUNTY PUBLIC SCHOOLS
SYMPTOM CHECKER

Name _____																															
Instructions: Please check your symptoms at home, select Y= Yes and N = No and record on this sheet.																															
	If you answer YES to any of the questions below, you must STAY at home. Contact your Primary Care Physician if symptoms persist.																														
	For weekends draw an X through the date. If you have any questions, please contact your school nurse.																														
Date:	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Have you been exposed to COVID-19 in the past 10 days?	Yes or No																														
Are you feeling sick?	Yes or No																														
Record Temperature here, if greater than 100.4 stay home																															
Do you have any of the following: cough, chills, difficulty breathing, excessive tiredness?	Yes or No																														
Do you have muscle aches, congestion, runny nose, sore throat?	Yes or No																														
Do you have a headache, nausea, vomiting, diarrhea, or loss of taste or smell?	Yes or No																														