COVID-19 Screening Form
Prince William County Schools

Name: (Last, First) ***Date:***

Background	***Sport/School***

Birth Date:
Grad Class:
Gender:

Temperature:

YES or NO	SYMPTOMS
	Fever or Body Chills
	Cough
	Shortness of Breathor Difficulty Breathing
	Fatigue
	Muscle or Body Aches
	Headache
	New Loss of Taste or Smell
	Congestion or Runny Nose
	Nausea or Vomiting
	Diarrhea

YES or NO	QUESTIONS
	Been in contact with a confirmed COVID-19 patient
	Visited an area affected with COVID-19
	Received a positive test result/diagnosis of COVID-19

Signature	***Date:***