**ORCCC DAILY HEALTH SCREENING**

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| *In the past 14 days have you or your child had contact with a positive COVID 19 individual?*  *In the past 14 days have you traveled out of approved states?* |  |  |  |  |  |
| *In the past 24 hours has your child had any of these symptoms? If yes child must remain out of childcare until symptom free for 72 hours.* |  |  |  |  |  |
| *Temperature of 100 F or above?* |  |  |  |  |  |
| *Cough?* |  |  |  |  |  |
| Sore throat? |  |  |  |  |  |
| *Difficulty breathing?* |  |  |  |  |  |
| *Gastrointestinal symptoms (diarrhea, nausea, vomiting?* |  |  |  |  |  |
| *New loss of taste or smell?* |  |  |  |  |  |
| *New muscle aches?* |  |  |  |  |  |
| *Has your child had any of the following symptoms in conjunction with any of the above symptoms?* |  |  |  |  |  |
| *Headache?* |  |  |  |  |  |
| Fatigue? |  |  |  |  |  |
| Runny nose, congestion or any other signs of illness |  |  |  |  |  |

Child’s name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I attest that I am answering the above questions truthfully. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent signature /date

I attest that I am answering the above questions truthfully. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent signature /date

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