White Cloud Public Schools

Building a Tradition of Excellence

www.whitecloud.net

Appendix D

Visitor Screening

Date: _____

Have you had any signs or symptoms of a fever in the past 24 hours such as chills, sweats, felt "feverish" or had a temperature that is elevated for you/100.0F or greater?

Yes No

Do you have any of the following symptoms?

- Cough
- Shortness of Breath or Chest Tightness
- Sore Throat
- Nasal Congestion/Runny Nose
- Myalgia (Body Aches)
- Loss of Taste and/or Smell
- Diarrhea
- Nausea
- Vomiting
- Fever/Chills/Sweats

Yes No

Have you traveled internationally or outside of the state in the last 14 days? Or, have you had any close contact in the last 14 days with someone with a diagnosis of COVID-19?

Yes No

Visitor Name (Printed): _____

Visitor Signature: _____

Building Signature: _____

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