ROXBURY TOWNSHIP PUBLIC SCHOOLS | 42 N. Hillside Avenue Succasunna, NJ 07876 | www.roxbury.org

ROXBURY COMMUNITY SCHOOL PARTICIPANT DAILY SCREENING FORM

Participants must complete this form before arrival to this program daily. If you've answered yes to any of these questions, please stay home and consult with your healthcare provider. Thank you!

Participant Name (First & Last): _____ Today's Date: _____

COVID-19 Related Symptoms

What was your temperature reading taken prior to attending this program? _____

Within the past 24 hours, have you experienced any of the following symptoms?

- ❑ New onset cough
- ❑ Fever of 100 degrees or higher
- ❑ Shortness of breath or difficulty breathing
- ❑ Sore throat
- ❑ Chills or repeated shaking with chills
- ❑ Muscle or body aches
- ❑ New onset headache
- ❑ Loss of taste or smell
- ❑ Congestion or runny nose unrelated to allergies
- ❑ Nausea or vomiting
- ❑ Diarrhea
- ❑ Fatigue
- ❑ No symptoms above are present

Have you or anyone in the household had close contact with someone who is sick?

- ❑ Yes
- ❑ No

Have you had close contact with anyone who tested positive for COVID-19 in the past 14 days? A close contact = being within 6 feet of a person who tested positive for COVID-19 for a prolonged period of time (approximately more than 10 minutes, as per New Jersey Department of Health).

- ❑ Yes
- ❑ No

Are you currently under quarantine?

- ❑ Yes; Date quarantine began: _____
- ❑ No

In the past 2 weeks, have you traveled from a state or country outside of NJ that has a travel advisory requiring quarantine?

- ❑ Yes
- ❑ No