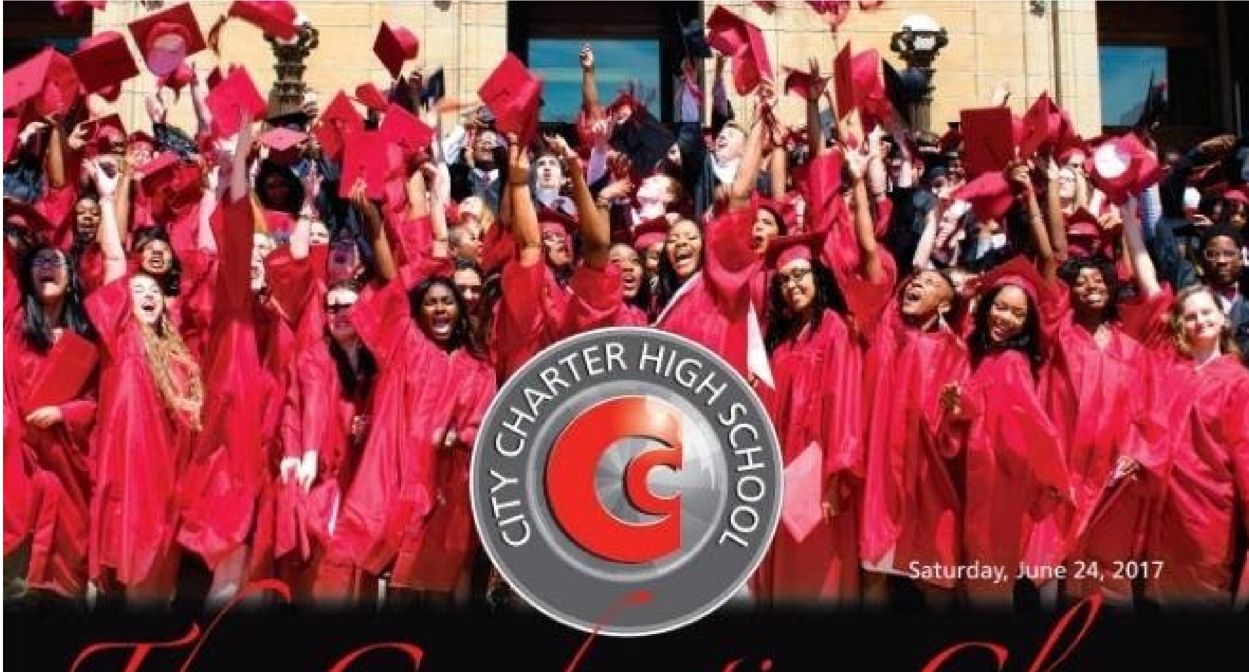
City High Pre-Entry Screening Form

Please complete this form each day before coming into the building

* Required



1. First Name *

2. Last Name *

3. Grade Level / Department *

Mark only one oval.

- 2021
- 2022
- 2023
- 2024
- Admin
- Technology
- Wellness
- Front/Back Office
- Cafeteria / Maintenance
- Visitor/Open House

4. Do you have a fever of 100.5 or above or are you taking any medication to treat or reduce a fever such as Ibuprofen (i.e. Advil, Motrin) or Acetaminophen (Tylenol)? *

Mark only one oval.

- Yes
  Skip to section 2 (Stay Home if you, or anyone in your household, has any of the symptoms)
- No

5. Are you fully vaccinated? (Note: Fully vaccinated is defined as two weeks following your Johnson & Johnson single vaccine shot or the second dose of the Pfizer or Moderna vaccine shot) *

Mark only one oval.

- Yes *Skip to question 11*
- No *Skip to question 6*

Stay Home if you, or anyone in your household, has any of the symptoms

STAY HOME!! STAY HOME!! Based on your reported symptoms, you are required to STAY HOME!! Please do not report to the school building!

Symptoms

6. Are you or anyone in your household experiencing any of the following? *

Mark only one oval.

- Cough
  Skip to section 2 (Stay Home if you, or anyone in your household, has any of the symptoms)
- Shortness of breath
  Skip to section 2 (Stay Home if you, or anyone in your household, has any of the symptoms)
- Difficulty breathing
  Skip to section 2 (Stay Home if you, or anyone in your household, has any of the symptoms)
- Loss of Smell
  Skip to section 2 (Stay Home if you, or anyone in your household, has any of the symptoms)
- Loss of taste
  Skip to section 2 (Stay Home if you, or anyone in your household, has any of the symptoms)
- None of the above

Symptoms

7. Are you, or anyone in your household, experiencing 2 or more of the following symptoms? *

Check all that apply.

- [ ] Fever (measured or subjective)
- [ ] Chills
- [ ] A sudden feeling of cold with shivering accompanied by a rise in temperature
- [ ] Muscle Pain
- [ ] Headache
- [ ] Sore throat
- [ ] Nausea or vomiting
- [ ] Diarrhea
- [ ] Fatigue
- [ ] Congestion or runny nose
- [ ] NONE

Symptoms

8. Is anyone in your household experiencing symptoms as described above? *

Mark only one oval.

- ( ) Yes
- ( ) No

Symptoms

9. Have you or anyone in your household been exposed to or gotten tested for COVID-19 and is awaiting their test results? *

Mark only one oval.

- ( ) Yes
  Skip to section 2 (Stay Home if you, or anyone in your household, has any of the symptoms)
- ( ) No

Symptoms

10. Have you or anyone in your household tested positive for COVID-19 within the past 14 days? *

Mark only one oval.

- Yes
  Skip to section 2 (Stay Home if you, or anyone in your household, has any of the symptoms)
- No

COVID Exposure- Vaccinated Persons

11. Have you or anyone in your household been exposed to or tested positive for COVID-19 within the past 14 days? *

Mark only one oval.

- Yes
  Skip to section 2 (Stay Home if you, or anyone in your household, has any of the symptoms)
- No

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