Greenfield CUSD #10 Covid 19 Self Assessment **Date:_____**

Student Names Grade

_____

_____

_____

_____

_____

Please put a check mark by the appropriate response.

TODAY,

____I am symptom free

____Fever or chills

____Cough

____Shortness of breath

____Headache

____Loss of taste or smell

____Congestion or runny nose

____Nausea or vomiting

____Diarrhea

I,_____, confirm that the responses above are true.

(Parent Signature)