John Paul II Polish School
24 Changebridge Rd., Montville NJ 07045

Weekly Health Screening Form

Date: _____

First name:_____

Last name:_____

Student _____ **Teacher** _____ **Staff** _____ **Parent** _____ **Other** (specify) _____

Question	**Response – YES** *(Provide date and details for all "YES" responses)*	**Response - NO**
Have you tested positive for Covid-19 in the past 7 days?		
Were you in close contact with a person who tested positive for COVID-19 in the past 7 days?		
Did you experience any of the following symptoms: **fever, chills, headache, muscle or body aches, congestion, runny nose, cough, diarrhea, fatigue, nausea, vomiting, loss of taste, loss of smell, shortness of breath, sore throat** in the past 7 days?		
Were you in close contact with a person who experienced the following symptoms: any of the following symptoms: **fever, chills, headache, muscle or body aches, congestion, runny nose, cough, diarrhea, fatigue, nausea, vomiting, loss of taste, loss of smell, shortness of breath, sore throat** in the past 7 days?		
Did you attend any social gatherings where social distancing was not possible in the past 7 days?		
Did you use any public transportation (e.g., bus, train, plane) where social distancing was not possible in the past 7 days?		