

Odessa School District #105

PO Box 248 Odessa, WA 99159

Superintendent
Dan Read
(509) 982-2668
FAX (509) 982-0163
www.odessa.wednet.edu

K-12 Principal
Jamie Nelson
(509)982-2603 Elementary
(509)982-2111 Secondary

Board of Directors
Ed Deife
Heather Valverde
Christine Crossley
Janie Steward
Carmen Weishaar

COVID-19 DAILY HEALTH SCREENING QUESTIONNAIRE

Please answer the following questions every day to the best of your ability and knowledge.

1. Measure your current body temperature with a thermometer (if available) and write it here _____ degrees

2. Since your last day at school, have you had any of the following occur:

- | | | |
|--|------------------------------|-----------------------------|
| A fever of 100.4° or higher, or a sense of having a fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| A cough that you cannot attribute to another health condition | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| A shortness of breath that you cannot attribute to another health condition | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| A sore throat that you cannot attribute to another health condition | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Congestion or runny nose that you cannot attribute to another health condition | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Fatigue and/or muscle aches that you cannot attribute to another health condition, or that may have been caused by a specific activity (such as physical exercise) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| A loss of taste or smell that you cannot attribute to another health condition | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chills or repeated shaking with chills that you cannot attribute to another condition | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Nausea or vomiting that you cannot attribute to another health condition | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| I have been diagnosed or tested positive for COVID-19 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Someone I live with or spend a lot of time with has symptoms or tested positive for COVID-19 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

3. If you answered YES to ANY of the items in Section 2:

- **Stay home and DO NOT enter the school**
- **For students:** Wait at the entry, you will be escorted to a Covid quarantine area until your parent/guardian arrives to pick you up.
- **For teachers/staff:** Please leave the building and call the office to explain your symptoms.

4. If you answered NO to ALL of the items in Section 2:

Printed Name: _____

Signature: _____ **Date:** _____

Thank you for helping to keep yourself, your family and our students safe and healthy!

*“Excellence in Education is the
Commitment of the Odessa School District”*