COVID 19-Daily Screening	
Child's	s Name: Date:
Please answer the following questions:	
1.	I have taken my child's temperature before coming to Bobbie Noonan's Child Care. Did he/she have a temperature? Yes No
2.	My child has not had a fever in the last 3 days and I have not given him/her fever reducing medicine. Yes No
3.	My child has not felt unwell with respiratory symptoms in the last few days. He or she has not had a cough, any shortness of breath, loss of smell or taste, high temperature, or difficulty breathing. Yes No
4.	No one my child has come in contact with is showing any signs of illness. For example: fever, cough, or respiratory symptoms. Yes No
If the answer is yes to any of these questions, you will be asked to keep your child home until no longer showing any signs of illness. Thank you for your honesty and help in answering these questions.	
Parent Signature:	
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Parent Signature:	