OLESEA'S ART STUDIO

COVID19 questionnaire // September 2021

Child's name _____

Parent's/ guardian's name _____

Today or in the past 24 hours, have you or any household members had any of the following symptoms?
(Circle please)

Fever?	YES	NO
Fever (temperature of 100.0°F or above), felt feverish, or had chills?	YES	NO
Cough? Sore throat?	YES	NO
Difficulty breathing ?	YES	NO
Gastrointestinal symptoms (diarrhea, nausea, vomiting)?	YES	NO
Abdominal pain?	YES	NO
Unexplained rash?	YES	NO
Fatigue	YES	NO
Headache?	YES	NO
New loss of smell/taste?	YES	NO
New muscle aches?	YES	NO
Any other signs of illness?	YES	NO
14 days contacts	YES	NO

In the past 14 days, have you had close contact with a person known to be infected with the novel coronavirus (COVID-19). If any of the symptoms detected, contact Olesea's Art Studio to notify of the health condition and contact the physician to get checked for COVID-19.

I have performed visual screening of my family members.

Your Name _____

Signature _____