COVID-19 Questionnaire

People with COVID-19 have had a wide range of symptoms reported – ranging from mild symptoms to severe illness.

Have you experienced **any** of the following in the last 14 days:

Symptoms	**Yes**	**No**	**Explain**
Cough			
Shortness of breath			
Difficulty Breathing			
Fever			
Chills			
Muscle pain			
Sore throat			
New loss of taste			
New loss of smell			
Nausea			
Vomiting			
Diarrhea			

Has **any** member in your household tested positive for COVID-19 or quarantined in the last 14 days? Yes_ No_ If yes, what date? _____ Next appointment date to be retested_____

Is **any** member in your household being quarantined for a possibility of COVID-19? Yes_ No_ If yes,explain_____
_____

Are any members in your household showing any symptoms of COVID-19? If yes, please explain_____
_____

Has **any** member of your household who did not have symptoms, **but** tested positive quarantined at least 14 days? Yes__ No__

___ I will report any COVID- 19 related issues pertaining to **any** member of my household to Quality Time Learning Center promptly.

Child' Name_____ Date_____
Parent Name_____ Signature_____