THE PRAIRIE SCHOOL

DAILY HEALTH TICKET

Completed by every adult entering school, every day

Date:____/____ Name:_____

Temperature:_____ Time Temperature Taken:_____ am

Mark **YES** or **NO** to experiencing any of the following symptoms:

YES	SYMPTOM	NO
	COUGH	
	FEVER/CHILLS	
	SHORTNESS OF BREATH	
	MUSCLE ACHES	
	SORE THROAT	
	NEW LOSS OF TASTE OR SMELL	
	DIARRHEA	
	HEADACHE	
	FATIGUE	
	NAUSEA OR VOMITING	
	Non allergy related CONGESTION OR RUNNY NOSE	

I have completed this form in full truth and attesting that I haven't had any of the symptoms above, or a fever in the last three (3) days, 72 hours, and have not taken fever-reducing medication.

Signature: _____