Rvsd 02/16/21

CCSD Access Form

Please help us take the precautionary measures needed to protect you and everyone in this building by answering the questions below.

Name (Print): _____ **Date:** _____

School/Grade: _____/_____

1. Do you have any of the following symptoms not tied to existing conditions or allergies?

☐ Cough	☐ Chills
☐ Shortness of breath	☐ Sore throat
☐ Fever	☐ Vomiting
☐ Repeated shaking with chills	☐ New loss of taste or smell
☐ Muscle pain	☐ Diarrhea
☐ Headache	☐ **None**

2. In the past **14 days**, have you been exposed to someone with **COVID-19** or been around anyone who has been sick? **Yes** ☐ **No** ☐

3. Are you currently taking any medication to treat or reduce fever such as ibuprofen (Advil/Motrin)? **Yes** ☐ **No** ☐

4. Have you been diagnosed by a physician in the last **14 days** with COVID-19? **Yes** ☐ **No** ☐
   If yes provide additional information below.

5. Temperature is below **100.4 degrees**. **Yes** ☐ **No** ☐

6. **TEMP:** _____

Additional Notes:

Signature: _____

Supervisor Signature: _____ **Title:** _____