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: ____________________________