



# DAILY SYMPTOM CHECK-LIST

Please review before coming to school  
each day

If you answer "YES" to any of the questions below, **STAY HOME** and follow the steps below:

- **Step 1:** Inform your school
- **Step 2:** To protect your privacy please call your School Nurse or the Director of Nursing Services if you need to report a positive test result or have been asked to self-quarantine
- **Step 3:** Follow In-School Learning Daily Decision Tree

Have you traveled outside Alaska within the past 14 days?

- Yes       No

Have you been in close contact with anyone who has tested positive for COVID-19?

- Yes       No

Have you been asked to self-quarantine because of close contact with an infected individual?

- Yes       No

Have you been tested for COVID-19?

- Yes       No

Have you received a **negative** test result yet?

- Yes       No

Do you have any of the following:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Fever/Chills?                                | <input type="checkbox"/> New Loss of Taste or Smell? | <input type="checkbox"/> Abdominal Pain? |
| <input type="checkbox"/> Cough?                                       | <input type="checkbox"/> Sore Throat?                | <input type="checkbox"/> New Rash?       |
| <input type="checkbox"/> Fatigue?                                     | <input type="checkbox"/> Congestion or Runny Nose?   | <input type="checkbox"/> New Joint Pain? |
| <input type="checkbox"/> Nausea or Vomiting?                          | <input type="checkbox"/> New Muscle or Body Aches?   |  |
| <input type="checkbox"/> Headache?                                    | <input type="checkbox"/> Diarrhea?                   |  |
| <input type="checkbox"/> Shortness of Breath or Difficulty Breathing? |  |  |