To ensure the safety of all students and staff, please fill out the following health information daily and turn into ATC when entering the building.

Name____Date _______________________

Today's Temperature___________________________

Have you had any of the following symptoms in the past 24 hours? **Y or N**
Fever (temperature over 100.4 without fever reducing medication), chills, cough, shortness of breath, fatigue, muscle or body aches, headache, loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea?

Have you, or anyone you have been in close contact with, been diagnosed with COVID-19 or placed in quarantine for possible exposure to COVID-19 in the last two weeks? **Y or N**

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