Palmer LifeWays
Covid-19 Questionnaire
New and Returning Families

*Indicate Yes or No and provide relevant comments.

Name: _____

Child Name _____

Has your child had a fever, or has he/she felt feverish recently (last 72 hours)? Yes No

Does your child have a cough? Yes No

Does your child have shortness of breath or any difficulty breathing? Yes No

Does your child have chills or repeated shaking with chills? Yes No

Does your child have any muscle pain? Yes No

Does your child have any recent onset of headache or sore throat? Yes No

Does your child have any other flu-like symptoms? Yes No

Does your child have any recent loss of taste or smell? Yes No

Has your child experienced any recent GI upset or diarrhea? Yes No

Are you or your child in contact with anyone who has been confirmed to be COVID-19 positive? Yes No

Have you or your child traveled in the past 14 days to any regions affected by COVID-19? Yes No

Has your child been tested for COVID-19? If yes, what was the result? Yes No
Positive Negative

Have you been diagnosed with COVID-19? If yes, when? Yes No

Date _____

Date: _____

Signature: _____