Health Screening Form - Student

Student Name: ________________________________

Date: _________________

Do you have fever or have you felt hot or feverish recently (14-21 days)?	Yes	No
Are you having shortness of breath or other difficulties breathing?	Yes	No
Do you have a cough?	Yes	No
Any other flu-like symptoms, such as gastrointestinal upset, headache, or fatigue?	Yes	No
Have you experienced recent loss of taste or smell?	Yes	No
Have you been in contact with any confirmed COVID19 positive patients in the last 14 days?	Yes	No
(students who are well but who have a sick family member at home with COVID should consider postponing driving lessons)	Yes	No
Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	Yes	No
Have you traveled in the past 14 days to any regions affected by COVID19?	Yes	No

Positive responses to any of these questions require immediate notification of management.

Student Signature: ______________________________

Please do not write below this line. Official Use Only

Staff signature: ______________________

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