SkillsUSA 2021
COVID-19 Pre-Screening Questionnaire

Student Full Name: ____________________________________________________

School Name: ________________________________________________________

Have you traveled to an area with known local or international spread of COVID-19 in the past 14 days? Required to answer. Single choice.

☐ Yes
☐ No

Have you, or anyone in your family, come into close contact (within 6 feet) with someone who has a suspected or confirmed COVID – 19 diagnosis in the past 14 days either at home or on a jobsite, etc.? Required to answer. Single choice.

☐ Yes
☐ No

Have you had a fever (greater than 100.4 F or 38.0 C) OR symptoms of lower respiratory illness such as cough, shortness of breath, or difficulty breathing in the past 14 days? Required to answer. Single choice.

☐ Yes
☐ No

Are you currently experiencing a fever (greater than 100.4 F or 38.0 C) OR symptoms of lower respiratory illness such as cough, shortness of breath, or difficulty breathing? Required to answer. Single choice.

☐ Yes
☐ No

CONSENT

By signing below, I attest that:
I have signed this form freely and voluntarily, and I am legally authorized to make decisions for the child named above.

Signature of Parent/ Guardian* (if child is under age 18) ________________________________ Date ____________

Signature of Student (if age 18 or over or otherwise authorized to consent) _________________________ Date ____________