WINDMILL DAY SCHOOL & CAMP 14 DAY TEMPERATURE AND SYMPTOM MONITORING WORKSHEET AS OF JUNE 2020

Dear Windmill Parents:

Windmill Day School and Camp has been busy keeping current on new regulations and policies regarding COVID 19 and safety practices to keep our children, staff and Windmill families as safe as possible upon reopening our doors on July 6, 2020. The following temperature and symptom monitoring worksheet will be **REQUIRED TO BE COMPLETED** and presented to us on your child's first day upon returning for our summer 2020 season. Without your completed 14 day checklist, your child **CAN NOT BE ADMITTED**. Please take your child's temperature daily and check off all the boxes in regards to symptoms daily. Windmill Day School and Camp will be using the recommended non-contact forehead thermometers for temperature taking each morning upon arrival.

Name: _____

DAY 1 Date: _____/_____/ 2020

Signature of parent completing _____

Temperature _____ F | time taken _____ am ☐ pm ☐ | type of thermometer used _____

Any fever reducing medicine in last 24 hours? No ☐ yes ☐

If yes…. When? _____

Symptoms check	Short of breath	Chest pain	Sore throat	stomachache	Loss of taste	Loss of smell
cough no ☐ yes ☐	no ☐ yes ☐	no ☐ yes ☐	no ☐ yes ☐	no ☐ yes ☐	no ☐ yes ☐	no ☐ yes ☐

DAY 2 Date: _____/_____/ 2020

Signature of parent completing _____

Temperature _____ F | time taken _____ am ☐ pm ☐ | type of thermometer used _____

Any fever reducing medicine in last 24 hours? No ☐ yes ☐

If yes…. When? _____

Symptoms check	Short of breath	Chest pain	Sore throat	stomachache	Loss of taste	Loss of smell
cough no ☐ yes ☐	no ☐ yes ☐	no ☐ yes ☐	no ☐ yes ☐	no ☐ yes ☐	no ☐ yes ☐	no ☐ yes ☐

DAY 3 Date: _____/_____/ 2020

Signature of parent completing _____

Temperature _____ F | time taken _____ am ☐ pm ☐ | type of thermometer used _____

Any fever reducing medicine in last 24 hours? No ☐ yes ☐

If yes…. When? _____

Symptoms check	Short of breath	Chest pain	Sore throat	stomachache	Loss of taste	Loss of smell
cough no ☐ yes ☐	no ☐ yes ☐	no ☐ yes ☐	no ☐ yes ☐	no ☐ yes ☐	no ☐ yes ☐	no ☐ yes ☐

Name: _____

DAY 4 Date: _____/_____/ 2020			Signature of parent completing _____		
Temperature _____ F	time taken _____ am ☐ pm ☐	type of thermometer used _____	Any fever reducing medicine in last 24 hours? No ☐ yes ☐ If yes…. When? _____		
Symptoms check cough no ☐ yes ☐	Short of breath no ☐ yes ☐	Chest pain no ☐ yes ☐	Sore throat no ☐ yes ☐	stomachache no ☐ yes ☐	Loss of taste no ☐ yes ☐ Loss of smell no ☐ yes ☐
DAY 5 Date: _____/_____/ 2020			Signature of parent completing _____		
Temperature _____ F	time taken _____ am ☐ pm ☐	type of thermometer used _____	Any fever reducing medicine in last 24 hours? No ☐ yes ☐ If yes…. When? _____		
Symptoms check cough no ☐ yes ☐	Short of breath no ☐ yes ☐	Chest pain no ☐ yes ☐	Sore throat no ☐ yes ☐	stomachache no ☐ yes ☐	Loss of taste no ☐ yes ☐ Loss of smell no ☐ yes ☐
DAY 6 Date: _____/_____/ 2020			Signature of parent completing _____		
Temperature _____ F	time taken _____ am ☐ pm ☐	type of thermometer used _____	Any fever reducing medicine in last 24 hours? No ☐ yes ☐ If yes…. When? _____		
Symptoms check cough no ☐ yes ☐	Short of breath no ☐ yes ☐	Chest pain no ☐ yes ☐	Sore throat no ☐ yes ☐	stomachache no ☐ yes ☐	Loss of taste no ☐ yes ☐ Loss of smell no ☐ yes ☐
DAY 7 Date: _____/_____/ 2020			Signature of parent completing _____		
Temperature _____ F	time taken _____ am ☐ pm ☐	type of thermometer used _____	Any fever reducing medicine in last 24 hours? No ☐ yes ☐ If yes…. When? _____		
Symptoms check cough no ☐ yes ☐	Short of breath no ☐ yes ☐	Chest pain no ☐ yes ☐	Sore throat no ☐ yes ☐	stomachache no ☐ yes ☐	Loss of taste no ☐ yes ☐ Loss of smell no ☐ yes ☐

Name: _____

DAY 8 Date: _____/_____/ 2020

Signature of parent completing _____

Temperature _____ F

time taken _____ am ☐ pm ☐

type of thermometer used _____

Any fever reducing medicine in last 24 hours? No ☐ yes ☐

If yes…. When? _____

Symptoms check cough	Short of breath	Chest pain	Sore throat	stomachache	Loss of taste	Loss of smell
no ☐ yes ☐	no ☐ yes ☐	no ☐ yes ☐	no ☐ yes ☐	no ☐ yes ☐	no ☐ yes ☐	no ☐ yes ☐

DAY 9 Date: _____/_____/ 2020

Signature of parent completing _____

Temperature _____ F

time taken _____ am ☐ pm ☐

type of thermometer used _____

Any fever reducing medicine in last 24 hours? No ☐ yes ☐

If yes…. When? _____

Symptoms check cough	Short of breath	Chest pain	Sore throat	stomachache	Loss of taste	Loss of smell
no ☐ yes ☐	no ☐ yes ☐	no ☐ yes ☐	no ☐ yes ☐	no ☐ yes ☐	no ☐ yes ☐	no ☐ yes ☐

DAY 10 Date: _____/_____/ 2020

Signature of parent completing _____

Temperature _____ F

time taken _____ am ☐ pm ☐

type of thermometer used _____

Any fever reducing medicine in last 24 hours? No ☐ yes ☐

If yes…. When? _____

Symptoms check cough	Short of breath	Chest pain	Sore throat	stomachache	Loss of taste	Loss of smell
no ☐ yes ☐	no ☐ yes ☐	no ☐ yes ☐	no ☐ yes ☐	no ☐ yes ☐	no ☐ yes ☐	no ☐ yes ☐

DAY 11 Date: _____/_____/ 2020

Signature of parent completing _____

Temperature _____ F

time taken _____ am ☐ pm ☐

type of thermometer used _____

Any fever reducing medicine in last 24 hours? No ☐ yes ☐

If yes…. When? _____

Symptoms check cough	Short of breath	Chest pain	Sore throat	stomachache	Loss of taste	Loss of smell
no ☐ yes ☐	no ☐ yes ☐	no ☐ yes ☐	no ☐ yes ☐	no ☐ yes ☐	no ☐ yes ☐	no ☐ yes ☐

Name: _____

DAY 12 Date: _____/_____/ 2020

Signature of parent completing _____

Temperature _____ F

time taken _____ am ☐ pm ☐

type of thermometer used _____

Any fever reducing medicine in last 24 hours? No ☐ yes ☐

If yes…. When? _____

Symptoms check cough	Short of breath	Chest pain	Sore throat	stomachache	Loss of taste	Loss of smell
no ☐ yes ☐	no ☐ yes ☐	no ☐ yes ☐	no ☐ yes ☐	no ☐ yes ☐	no ☐ yes ☐	no ☐ yes ☐

DAY 13 Date: _____/_____/ 2020

Signature of parent completing _____

Temperature _____ F

time taken _____ am ☐ pm ☐

type of thermometer used _____

Any fever reducing medicine in last 24 hours? No ☐ yes ☐

If yes…. When? _____

Symptoms check cough	Short of breath	Chest pain	Sore throat	stomachache	Loss of taste	Loss of smell
no ☐ yes ☐	no ☐ yes ☐	no ☐ yes ☐	no ☐ yes ☐	no ☐ yes ☐	no ☐ yes ☐	no ☐ yes ☐

DAY 14 Date: _____/_____/ 2020

Signature of parent completing _____

Temperature _____ F

time taken _____ am ☐ pm ☐

type of thermometer used _____

Any fever reducing medicine in last 24 hours? No ☐ yes ☐

If yes…. When? _____

Symptoms check cough	Short of breath	Chest pain	Sore throat	stomachache	Loss of taste	Loss of smell
no ☐ yes ☐	no ☐ yes ☐	no ☐ yes ☐	no ☐ yes ☐	no ☐ yes ☐	no ☐ yes ☐	no ☐ yes ☐