Kānehūnāmoku
Voyaging Academy

COVID-19 Daily Self Health Screening Form

Name

First Name

Last Name

Temperature ˚F *

Do you have any of the following symptoms:

Fever within the past 24 hours? *

Yes No

Coughing/Sneezing? *

Yes No

Sore throat? *

Yes No

Shortness of breath? *

Yes No

Chills? *

Yes No

Muscle Pain? *

Yes No

Nausea/Vomiting? *

Yes No

Diarrhea? *

Yes No

New loss of taste or smell? *

◯ Yes ◯ No

***If you answered yes to any of the questions above, please explain.**

(EX: Muscle pain is caused from working out.)

And/or any of the following within the past 14 days:

In the last 14 days, I/family member in my household traveled inter-island or out of state? *

◯ Yes ◯ No

Have you or anyone in your household been in contact with people infected, or diagnosed with COVID-19? *

◯ Yes ◯ No

Do you reside in a community where community-based spread of COVID-19 is occurring? *

◯ Yes ◯ No

***If you answered yes to any of the questions above, please explain.**

If staff or visitors answer yes to any of these questions, you will be asked to isolate at home and to see a medical professional for advice. Documentation from a doctor or a COVID-19 test with a NEGATIVE RESULT may be requested prior to returning to in-person sessions.

**All completed forms shall be saved.*

Preview PDF

Submit