COVID-19 Student Daily Health-Screening Questionnaire

Please complete the following questionnaire in the morning before school and send the document with your child to school on the first on Tuesday or Thursday of the week.

STUDENT Name: _____

PARENT/GUARDIAN Name: _____

Date: _____

Questions	*Please Check One*	
	Yes	**No**
1. Have you knowingly been in close or proximate contact in the past 10 days with anyone who has tested positive through a diagnostic test for COVID-19?	❑	❑
2. Have you tested positive through a diagnostic test for COVID-19 in the past 10 days	❑	❑
3. Are you experiencing any symptoms of COVID-19, such as: Fever ≥100°F or chills; Cough; Shortness of breath or difficulty breathing; Fatigue; Muscle or body aches; Headache; Loss of taste or smell; Sore throat; Congestion or runny nose; Nausea or vomiting; Diarrhea? ***Check "No" if the nature of the symptom (duration, intensity, etc.) is consistent with a pre-existing condition of which you are already aware that is not new, worsening, or different from its usual presentation. (i.e., seasonal allergies, asthma, sinus, tension or migraine headaches, inflammatory bowel disease, Crohn's Disease, Lactose Intolerance, Irritable Bowel Disease, Chronic Fatigue Syndrome).**	❑	❑
4. Have you traveled internationally outside the United States within the past 10 days? https://coronavirus.health.ny.gov/covid-19-travel-advisory	❑	❑

If you have answered "YES" to any questions above (1-4) please:

- ***Do not place your child on the bus***
- ***Do not enter any school buildings***
- ***Immediately notify your child's teacher or School Nurse***

❑ **I have reviewed and answered to the best of my knowledge "NO" to all of the questions above.**

❑ **I understand if at any time if my symptoms change, I will immediately notify an administrator.**

Parent Signature:_____ **Date:**_____

Revised March 29, 2021