COVID 19 SCREENING QUESTIONS – FOR STUDENTS

Student Name_____________________________________

Does your child have any of the following symptoms:

- Fever of 100.00 or more or chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

Been in close contact in the last 14 days with anyone who has tested positive for Covid 19 or who has had symptoms of Covid 19

Experienced symptoms of Covid 19 including a temperature of greater than 100 in the past 14 days

Tested positive through a diagnostic test for Covid 19 in the past 14 days

Traveled internationally or from a state with widespread community transmission of Covid 19 per the New York State Travel Advisory in the past 14 days.

Are you experiencing any of the symptoms or scenarios above?

No_______________Yes_________________

If you answered Yes to any of the above, your child is not cleared to come to school.

Parent Signature__________________________________Date______________________