Weekly Student Health Screening

Date ___________________

Child's Name ________________________

Homeroom ________________

Has your child come in close, regular contact (within 6 feet) of someone who has a laboratory confirmed COVID-19 diagnosis within the past 14 days?

Yes ☐ No ☐

Does your child have any of the following: fever or chills, cough, shortness of breath or difficulty breathing, body aches, headache, new loss of taste or smell, sore throat?

Yes ☐ No ☐

Has your child traveled to any state not contiguous with New York in the last 14 days?

Yes ☐ No ☐

Does your child feel well today?

Yes ☐ No ☐

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